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PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED,

Plaintiff-Appellee,

v.

BRUCE U. KOZLOWSKI, Director of Virginia Department of Medical Assistance Services,

Defendant-Appellant,

and

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

No. 93-2572

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED,

Plaintiff-Appellee,

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellant,

and

BRUCE U. KOZLOWSKI, Director of Virginia Department of Medical Assistance Services,

Defendant.

No. 94-1134

Appeals from the United States District Court
for the Eastern District of Virginia, at Richmond.
Robert R. Merhige, Jr., Senior District Judge.
(CA-93-402-R)

Argued: June 8, 1994

Decided: December 5, 1994

Before ERVIN, Chief Judge, and NIEMEYER and WILLIAMS, Circuit Judges.

Affirmed by published opinion. Chief Judge Ervin wrote the opinion, in which Judge Williams joined. Judge Niemeyer wrote a concurring and dissenting opinion.

COUNSEL

ARGUED: Richard Alan Olderman, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellant Secretary; William Henry Hurd, Deputy Attorney General, OFFICE OF THE ATTORNEY GENERAL, Richmond, Virginia, for Appellant Kozlowski. Peter F. Nadel, ROSENMAN & COLIN, New York, New York, for Appellee. **ON BRIEF:** Frank W. Hunger, Assistant Attorney General, Helen F. Fahey, United States Attorney, Barbara C. Biddle, Civil Division. UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellant Secretary; James S. Gilmore, III, Attorney General of Virginia, Pamela M. Reed, Assistant Attorney General, OFFICE OF THE ATTORNEY GENERAL, Richmond, Virginia, for Appellant Kozlowski. Joseph V. Willey, ROSENMAN & COLIN, New York, New York; David G. Shuford, MAYS & VALENTINE, Richmond, Virginia, for Appellee.

OPINION

ERVIN, Chief Judge:

Rehabilitation Association of Virginia, Inc. (the Association) brought this suit against Bruce Kozlowski, director of Virginia's Department of Medical Assistance Services (Virginia), and Donna Shalala, Secretary of the United States Department of Health and Human Services (DHHS or the Secretary) challenging the legality of certain aspects of Virginia's Medicaid plan and seeking prospective injunctive relief. On cross-motions for summary judgment, the district court entered judgment in favor of the Association, and Virginia and DHHS now appeal. For the reasons set forth below, we affirm.

I.

Briefly stated, Medicare, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc, is a federally-run program, enacted in 1965, to provide financing for medical procedures for certain disabled individuals and people 65 years of age; 42 U.S.C. §§ 426(a), 1395c. Medicare has two parts, Part A and Part B; Part A, 42 U.S.C. §§ 1395c to 1395i-4, provides reimbursement for inpatient hospital care and related post-hospital, home health and hospice care. 42 U.S.C. § 1395d. Enrollment in Part A is essentially automatic. Part A includes limited cost-sharing provisions in the form of annual deductibles for inpatient hospital service and payments by enrolled individuals of an amount of "coinsurance" that depends on the length of hospital stay. 42 U.S.C. § 1395e. In addition, some individuals who do not directly meet the basic

criteria for enrollment may enroll and are required to pay premiums. 42 U.S.C. §§ 1395i-2, 1395i-2a.

Medicare Part B, 42 U.S.C. §§ 1395j to 1395w-4, is a supplemental voluntary insurance program. Under Part B, individuals entitled to Part A benefits and certain others, *see* 42 U.S.C. § 1395o, may purchase supplementary insurance for hospital out-patient services, physician services, and other medical services not covered under Part A. 42 U.S.C. § 1395k. Part B also includes a series of cost-sharing provisions. Enrollees must pay a monthly premium and an annual deductible, currently $100. 42 U.S.C. §§ 1395l(b), 1395(r). (There is an exemption from the application of the annual deductible for certain services, *see* 42 U.S.C. § 1395l(b)). As to payments of charges after the deductible is exhausted (or where it does not apply), the federal government will pay 80% of the "reasonable charge" for the services. 42 U.S.C. § 1395l(a). The amount that constitutes a reasonable charge is set annually by the Secretary. 42 U.S.C. § 1985w-4. The service provider can charge the beneficiary for the remaining 20% of the reasonable charge. *Id.* This charge is usually referred to as a copayment or coinsurance. If the physician is a participating physician, he "takes assignment" in Medicare parlance, and cannot charge an amount greater than the reasonable charge. If the physician does not take assignment, the physician's fee may exceed the "reasonable charge" for the service provided, and the doctor may bill the patient for not only the difference between the reasonable charge and the federal payment, but also the difference between the actual charge and the reasonable charge as well. This is commonly referred to as "balance billing."

Also enacted in 1965, Medicaid, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, established a federal-state cooperative cost-sharing program to provide necessary medical assistance to families and individuals with insufficient income and resources. While a state's participation in Medicaid is not mandatory, once a state does enter into an agreement with the United States it receives federal funds for its Medicaid program. Participating states are required to comply with the Medicaid Act and its implementing regulations issued by the DHHS. 42 U.S.C. §§ 1396a, 1396c.

Under Medicaid, each state develops a schedule or methodology that establishes the fee that the state will pay a service provider for every item or service covered under the state's Medicaid plan. Where Medicare and Medicaid cover the same services, the state Medicaid fee amount is almost always less than the reasonable charge for services that the federal government sets for Medicare reimbursement; it is also generally even less than the 80% of the reasonable charge figure that the government pays under Medicare's Part B insurance plan. Service providers who participate in the Medicaid program are required to accept payment of the state-denoted Medicaid fee as payment in full for their services, i.e., they are required to take assignment, and may not attempt to recover any additional amounts elsewhere. Medicaid is essentially a payer of last resort, and one of the requirements of a state Medicaid plan is that it attempt to identify and collect other insurance or source of health care funding available to a Medicaid participant (i.e., a form of subrogation). 42 U.S.C. § 1396a(a)(25).

The Medicaid and Medicare statutes intersect for coverage of the population of the disabled or people 65 or over (eligible for Medicare) who are also poor (eligible for Medicaid). These people are called dual eligibles or crossovers. In addition, there is another group of whom we must take notice, called the "qualified medicare beneficiaries" or QMBs. As originally defined, QMBs included persons eligible for Medicare and who met certain statutory requirements of poverty, but who did not meet a state's eligibility requirement for Medicaid; they are referred to as "pure QMBs." Subsequently, the definition of QMB was changed so that ineligibility for Medicaid was removed; as such, the current definition of QMBs embraces two subsets of individuals: Medicare eligibles who are also eligible for Medicaid benefits (i.e., dual eligibles), and Medicare eligibles who are not eligible for Medicaid benefits but who meet certain criteria of poverty (i.e., pure QMBs).[1] For the sake of clarity, we use the term QMBs to refer to both subgroups, and refer to one or the other subgroup only by its identified name.

While QMBs are, by definition, eligible for Medicare Part A enrollment and Part B insurance coverage, because they are impoverished there exists the very real danger that they will be unable to afford to buy themselves the Part B supplementary health coverage or pay Part A or Part B's deductibles or coinsurance amounts. Thus, the

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[1] Specifically, QMBs are defined as individuals who are eligible for Medicare Part A benefits, have incomes not exceeding the federal poverty line, and whose resources do not exceed twice the amount set as the maximum for receiving benefits under the supplemental security income program. 42 U.S.C. § 1396d(p)(1).

people for whom the safety net is most needed are also those who, left to their own, could not place themselves within its embrace. Since the outset, at least as to dual eligibles, the Medicare and Medicaid statutes have addressed this problem. The response was to create a "buy-in" program, under which states participating under Medicaid use Medicaid funds (i.e., state funds for which federal matching funds under Medicaid are available) to pay the premiums to enroll the QMB[2] in the Medicare Part B insurance program (or the premium to enroll in Part A coverage for those people for whom the statute so required), and pay the deductibles and coinsurance payments that beneficiaries subsequently incurred under Part A or Part B. For dual eligibles, the state gets a real deal, because, given that Medicaid is treated as a payor of last resort, by enrolling dual eligibles for Part B coverage, the primary financial payment for services received comes from the federal government for any services that are covered under both Medicare and Medicaid. In other words, states use their Medicaid dollars, some of which are themselves federal in origin, to buy their QMBs into the federal program, thus shifting the primary payment for costs from the state Medicaid program to the federal Medicare program.

Thus, for a QMB, the state buys the individual into Medicare Part B insurance by paying the premiums for Part B insurance as well as the annual deductible. When

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[2] Although the buy-in program originally only extended to dual eligibles, it was extended in the 1980s to include pure QMBs as well, as discussed below.

the beneficiary incurs costs for services covered by Medicare ("Medicare services") above the deductible, the federal government pays 80% of the reasonable costs of the Medicare services received. The central question in this lawsuit involves the remaining 20%, i.e., the copayment representing the difference between the federal government's payment and the total amount of the "reasonable charge" that usually would be paid by the beneficiary but for the fact that the beneficiary is too poor to pay this amount herself. The difficulty arises from the fact that, as noted above, the Medicaid fee for a service is almost always lower than the Medicare reasonable charge. When that is the case, is the state required to reimburse the service provider for the entire 20% of the Medicare reasonable charge not covered by the federal payment, or is it only required to reimburse any difference between the federal 80% and the Medicaid reimbursement fee for that service?[3] In other words, is the formula for the state's contribution:

> Medicare reasonable charge – federal Medicare contribution

or is it:

> state Medicaid fee – federal Medicare contribution?

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[3] For example, say that for a particular service, the reasonable charge under Medicare is $100. The federal government reimburses $80 (assuming the deductible has been exhausted). If the Medicaid rate for that service is $90, does the state have to pay $20 or $10? And if the Medicaid rate for that service is $75, does the state pay $20 or nothing?

The selection of one formula over the other involves the characterization of the program as either primarily a Medicare program or primarily a Medicaid program. To say that the state is required to contribute the 20% difference is to see the program as being a Medicare program that is being partially financed with Medicaid dollars. To say that the state only has to contribute funds to bring the payment to the Medicaid amount, which means in some instances that the state need pay nothing, because the Medicaid cap is below the amount of the federal Medicare contribution, is to see the program either as a Medicaid program using primarily federal funds or, using the payor of last resort approach, to see it as a Medicaid program[4] where the 80% federal Medicare amount is viewed simply as a third party "primary" insurance program (that is not paying the amount that it is statutorily supposed to pay), essentially ignoring the 20% beneficiary/state contribution, and viewing the state contribution as a "pure" Medicaid contribution rather than Medicaid funds going for reimbursement of Medicare services.

The position taken by the Secretary is that the state contribution requirement ends at the level of the state's Medicaid fee cap. As a result, some states have altered their Medicaid plans relating to buy-ins accordingly. As of January 1, 1991, Virginia pays all of a QMB's Medicare Part B premium and deductible, but pays a QMB's coinsurance only to the extent that the Medicaid rate for the

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[4] We note in passing the incongruity of characterizing this as a Medicaid program when the pure QMBs are definitionally not eligible for Medicaid assistance.

service provided exceeds the amount the federal government pays under Part B. Thus, providers of Medicare services to QMBs do not receive the same payment for their QMB patients as for all other Medicare patients, but instead are eligible under the Virginia plan only to receive the greater of 80% of the Medicare fee or the full Medicaid fee, provided that the Medicaid fee is no greater than 100% of the Medicare fee.[5]

In addition to computing fees for Medicare services received by QMBs based on the Medicaid rate, the current Virginia plan does not directly reimburse physical therapy providers of the type who are the plaintiffs in this suit. The plan prohibits rehabilitation agencies from billing the Virginia Department of Medical Assistance Services (the state Medicaid administrator) directly for the amount owed for Medicare Part B deductibles and coinsurance on behalf of QMBs. Instead, the rehabilitation agencies must seek reimbursement for such amounts from the nursing facilities in which the beneficiaries are located, which are expected to submit those amounts to the state agency in their cost reports. The state agency then bundles these costs into a per diem rate paid to the nursing facility. Unfortunately, there is a per diem cap on

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[5] Neither the Secretary nor the Association addresses the hypothetical situation in which the Medicaid fee is greater than the full Medicare reasonable charge. Under the Secretary's theory, the state presumably would pay the greater amount; when pressed at oral argument on this point, the attorney for Virginia declared that it would certainly comply with this counterfactual scenario if it ever occurred, and that it would not insist that the Medicare amount capped its payment requirement.

nursing facility fees, and there is little prospect in reality that the bundling contemplated in fact occurs.

The Association, which is an association of rehabilitation service providers in Virginia, brought this suit seeking only injunctive relief against Kozlowski, head of the Virginia Medicaid program, and Shalala, head of the federal Medicare and Medicaid programs, under both the Medicare and Medicaid statutes directly as well as under 42 U.S.C. § 1983, alleging violations of the Medicare and Medicaid provisions in both the adoption of the Medicaid cap on QMB Part B reimbursement as well as in Virginia's payment program to nursing facilities rather than directly to the actual providers. The state offered several affirmative defenses including lack of standing and Eleventh Amendment immunity. On cross motions for summary judgment, the district court found for the Association on both the cap amount as well as the payment system, and ordered Virginia to utilize the 20% Medicare figure as the reimbursement amount and to pay such reimbursement directly. Virginia and DHHS appealed, and this court stayed the mandate of the district court's order pending resolution on appeal.

II.

We begin with Virginia's two defenses to this suit, both of which may be handled with dispatch. First, Virginia claims that the suit must fail because it is barred by the Eleventh Amendment. The suit seeks prospective, injunctive relief only, rather than any form of retroactive compensatory damages, and is brought against Kozlowski, not the State. Such a suit is allowed under *Ex*

parte Young, 209 U.S. 123 (1908), *Edelman v. Jordan*, 415 U.S. 651 (1974), and their progeny, and this defense is completely meritless.

Second, Virginia again asserts that the Medicaid and Medicare Acts do not provide standing to the rehabilitation providers to bring this suit under § 1983. We need not tarry over this argument, for it already has been decided, both by this circuit and by the Supreme Court. In *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653 (4th Cir. 1989), *aff'd sub nom. Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), Virginia asserted that the Virginia Hospital Association lacked standing to challenge Virginia's rates under the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A). Both this court and the Supreme Court rejected that contention, finding that the provision in question created enforceable rights on behalf of the service providers. The analysis set out in those opinions as to the Boren Amendment is equally applicable in this instance to the related QMB provisions of 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(a), 1396d(p). Where the state refuses to pay what the providers insist is the proper amount of the copayment for QMBs required under the Medicaid Act, the providers have standing to challenge the state's interpretation of the relevant provisions.

III.

There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein

demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

It is thus with some sympathy that we read the Secretary's brief, which calls the court to defer to her expert judgment under the aegis of *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). Nevertheless, while *Chevron* is regularly cited by administrative agencies as a backstop to support their positions, it must be clear that that case did not replace Article III of the Constitution. As the opinion in *Chevron* makes clear:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress had directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.[9] If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.
>
> [9]The judiciary is the final authority on issues of statutory construction and must reject

> administrative constructions which are contrary to clear congressional intent. If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.

Id. at 842-43 (citations and footnotes omitted). The task in the first instance for this court therefore is to examine the statute to determine whether the statute clearly speaks to the question of the amount of the Medicare copayment for which a state is responsible under the Medicare buy-in provisions. It is only if the statute is silent or ambiguous that we must look to the Secretary's interpretation to provide guidance.

The particular provisions involved in this case have been the subject of repeated tinkering by Congress, and on each occasion the legislative history has provided some information that contradicts other information as to Congressional intent. As noted below, there is a particular element of "Congressional dicta" in the form of post-enactment legislative history involved in these cases that requires an accounting. Both the Secretary and the Association are to be commended on their briefs, and each offers a reasonably good explanation of the development of the statutes over time, but they are contradictory stories in important respects. Given the extensive changes that have occurred to these statutes over time, the only way to explain the present posture is to begin at the creation and work forward through those changes.

A.

The Social Security Amendments of 1965 included in a single massive bill the initial Medicaid and Medicare provisions. The buy-in provision appeared in § 121(a). It stated:

> A State plan for medical assistance must –
>
> * * *
>
> (15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by [Medicare], provide –
>
> > (A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and
> >
> > (B) where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to any such individual under the insurance program established by part B of such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 70 Stat. 286, 1965 U.S.C.C.A.N. 305, 370-73 (codified prior to repeal at 42 U.S.C. § 1396a(a)(15)). As to Medicare Part A, this provision is straightforward: the state must pay the full deductible. As to Part B, the parties read it differently. The Association reads it to

mean that a state can pay the full amount of the deductible and cost-sharing under Part B; however, the state can also pay less than the full amount, but if it does so, it must still pay something of the amount due, and the amount it must pay is to be based on a figure reasonably related to the beneficiary's income. In no event, anyway, can it not pay at all. The Secretary, on the other hand, interprets this provision to mean that state contribution towards Part B was completely optional.[6]

We believe it clear, based on the plain language of the statute and the commentary in the legislative history that the Association's interpretation is the correct one. The language of the statute seems clearly to indicate that if the state pays less than all of the deductible or cost sharing under the buy-in provision, "the portion thereof which is met shall be determined on a basis reasonably related . . . to such individual's income or his income and resources." Two points confirm this reading. First, we believe that the legislative history eliminates any ambiguity that the statute contains. The general discussion of the bill includes the following commentary:

> A State medical assistance plan may provide for the payment in full of any deductibles or cost

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[6] Whatever the answer as to the amount of the State's payment, it should be noted that the buy-in requirement did not apply to all dual eligibles. Under § 102 of the 1965 law, the Secretary was authorized to enter into buy-in agreements only as to Medicaid beneficiaries who were receiving *cash assistance* from the states, not from the entire pool of Medicaid beneficiaries. See 1965 U.S.C.C.A.N. at 334. This was codified at 42 U.S.C. § 1395v. The 1967 Amendment broadened this provision to allow buy-in agreements for all dual eligibles.

> sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual *to assume a portion of such costs*, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards – under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance – to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals *to share in the cost* shall not be an undue burden on them.

S. Rep. No. 404, 89th Cong., 1st Sess., 1965 U.S.C.C.A.N. 1943, 2020 (emphasis supplied). The emphasized elements clearly disclose a Congressional intent that the language of the statute did not allow the states to opt out of the buy-in. Second, both the statute and the commentary provide for the Secretary to establish rules as to how much less the State can pay if it pays less than everything. If the statute allowed a state to pay *nothing*, it would be quite odd for the statute to then require the Secretary to establish strict regulations as to how much the state has to pay once it gets into the game. The whole point of the Secretary's regulations keying the portion of State contribution to the beneficiary's income and resources aims to protect the poor, elderly individual from financial devastation as a result of illness; a reading of the statute allowing the state to opt out entirely vitiates

the whole purpose of that provision by allowing the full burden of the copayment to fall on her shoulders.

Thus, from the beginning, the statute required state coverage of Part A coinsurance costs to be mandatory and total, while Part B coverage was also mandatory, but not necessarily total. If Part B coverage was less than total, it had to be keyed to the beneficiary's income and resources in accordance with DHHS rules.

B.

In 1967, Congress tinkered with the statute. Section 235(a)(3) of the Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, 1967 U.S.C.C.A.N. 923, 1031, amended 42 U.S.C. § 1396a(a)(15) to remove the differences between state requirements for the treatment of costs under Part A and Part B. It did so by rewriting the statute as follows:

> A State plan for medical assistance must –
>
> * * *
>
> (15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by [Medicare], provide –
>
> ~~(A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and~~
>
> ~~(B)~~ where, under the plan, all of any deductible, cost sharing, or similar charge

> imposed with respect to ~~any~~ such individual under the insurance program established by ~~part B of~~ such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Under this provision, Part A and Part B are treated uniformly, and the State may impose a deductible, but, as the accompanying Senate report notes,

> the effect of the change would be to no longer require that a State plan meet the cost of the deductibles imposed under Part A of [Medicare] and to require that the plan relate any deductibles imposed under the hospital insurance program, as well as the supplementary medical insurance program, of [Medicare] to the income of the individuals covered under the plan.

S. Rep. No. 744, 90th Cong., 2d Sess. (1967), reprinted in 1967 U.S.C.C.A.N. 2834, 3142.[7] Congress also broadened the coverage of the program to include *all* dual eligibles as opposed to simply those receiving cash assistance, see 1967 Amendments § 222(a), (b) (reprinted in 1967 U.S.C.C.A.N. at 1022-23), codified at 42 U.S.C. § 1395v. In

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[7] Beside this commentary, other portions of the Senate report confirm our view that Congress understood that state payments under Part B, and now Part A, if less than total had to be keyed to the dual eligible's income and resources. See 1967 U.S.C.C.A.N. at 3019 (discussing comparability requirement problem and exception to allow states to "meet[ ] part or all of the deductibles, cost sharing, or similar charges under part B"); *id.* at 3136 (same).

addition, Congress made such buy-in agreements essentially mandatory for the states participating in the Medicaid program by providing that the federal government would not provide Medicaid matching funds to cover any costs incurred under the Medicaid program where the individual could have been enrolled in Medicare Part B but was not. *Id.* § 222(c), 1967 U.S.C.C.A.N. at 1023, now codified at 42 U.S.C. § 1396b(b).

Thus, after the 1967 amendments took effect, all dual eligibles could participate in the buy-in program; the States would not receive funds if they did not buy-in their dual eligibles; and the States' required contribution under the buy-in included premiums, and deductibles and cost-sharing on either a full basis or a less than full basis complying with strict rules relating the amount of State contribution to the beneficiary's income and resources. Thus it stood for almost 20 years.

C.

In 1986, Congress revisited this area, and it is here that the strongest disagreements between the parties arise. An extensive series of amendments to the Social Security provisions was included in the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 1986 U.S.C.C.A.N. (100 Stat.) 1874 (1986) (OBRA). One series of amendments was designed to allow and encourage the states to expand the coverage of their Medicaid programs to additional needy individuals whose income fell between the SSI limit and the federal poverty line. Because this expansion was entirely voluntary, however, the bill also included a backup provision, which was the

initial introduction of QMBs (both the population and the term) into the Medicaid buy-in provision of Medicare. Again at the option of the states, the amendments authorized them to use their Medicaid funds "for medicare cost-sharing . . . for qualified medicare beneficiaries . . . . " OBRA § 9403(a), 1986 U.S.C.C.A.N. (100 Stat.) at 2053 (codified as amended at 42 U.S.C. § 1396(a)(10)(E)(i)). Qualified medicare beneficiaries were defined as individuals eligible for Medicare Part A insurance but not eligible for Medicaid, and who had incomes no greater than a state-determined limit (but that limit could not exceed the federal poverty line) and resources no greater than the maximum for benefits under the supplemental security income program. *Id.* § 9403(b), 1986 U.S.C.C.A.N. (100 Stat.) 2053-54 (codified as amended at 42 U.S.C. § 1396d(p)(1)).

Medicare cost-sharing was explicitly defined in the statute.

> The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary:
>
> (A) Premiums under part B . . . ;
>
> (B) Deductibles and coinsurance [under Part A];
>
> (C) The annual deductible [under Part B];
>
> (D) The difference between the amount that is paid under [the relevant payment section of Part B] and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent."

Id. § 9403(d), 1986 U.S.C.C.A.N. (100 Stat.) at 2054 (codified at 42 U.S.C. § 1396d(p)(3)). Part (D) of the definition seems quite strongly to indicate that the cost-sharing requirement included *all* of the copayments, i.e., the difference between the federal 80% payment and 100% of the reasonable charge.

This is not the end of the matter, however. Another amendment provision stated that "the medical assistance made available to a qualified medicare beneficiary . . . shall be limited to medical assistance for medicare cost-sharing . . . , subject to the provisions of subsection (n) and [42 U.S.C. § 1396o]." *Id.* § 9403(c), 1986 U.S.C.C.A.N. (100 Stat.) 2054 (codified at numeral VIII after 42 U.S.C. § 1396a(a)(10)(E)). The first half of this sentence makes perfect sense: it merely says that QMBs get state support for Medicare cost-sharing, and don't get to "piggy-back" that into full Medicaid support they are not otherwise eligible to receive under the state Medicaid program. This is placed among a series of provisions set down in text form following 42 U.S.C. § 1396a(a)(10), which is the subsection that lists various groups that a state's Medicaid plan must cover. All of these items, set off by roman numerals in the subsequent text, are intended to clarify that the fact that some groups are required to receive certain benefits under the state Medicaid plan doesn't mean that other groups must be afforded identical benefits. The justification for all of these clarifiers arises from Congress' initial concern that the states not provide better Medicaid benefits to the more well off than to the abject poor, and its response through the inclusion in the statute of a requirement that no group get a better set of benefits than any other group.

Of course, with some groups, however, Congress itself wanted better or different benefits provided, and once it recognized this tension was causing consternation among the states, it began in the 1967 amendments to insert these provisions to overcome the equality of benefits provision. See note 7, *supra*. Thus, this provision simply indicates, among the other clarifiers, that QMBs, who definitionally were not qualified for state Medicaid benefits, could obtain Medicaid assistance to get them into Medicare Part B and nothing more.

The second half of the sentence, "subject to the provisions of [42 U.S.C. § 1396a(n)] and [42 U.S.C. § 1396o]," is somewhat more difficult to understand. As passed in 1986 under OBRA, 42 U.S.C. § 1396a(n) provides:

> In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may provide* payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service *for eligible individuals who are not qualified medicare beneficiaries.*

COBRA § 9403(e), 100 Stat. 2054-55 (emphasis supplied). The Secretary and Virginia lean very heavily on the word "may." In their view, the fact that the statute says that the "State plan may provide payment" means that it may, but it doesn't have to, pay an amount that exceeds the Medicaid fee schedule amount for the particular item or service in question. The Association, on the other hand, sees

the "may" as being simply a lifting of a barrier; while states under Medicaid are not allowed to pay more than the plan amount, the statute here, to clarify any confusion about whether the state may pay the full 20% included as an item in the Medicare cost sharing definition, tells the state that it may in this instance go ahead and break the barrier. Although we believe that the Association's explanation is highly plausible, given the connection between this provision and those allowance provisions set out in text form after § 1396a(a)(10), we believe that a better understanding appears for this provision.

Neither the Secretary's nor the Association's explanation grasps one of the central problems with this provision: at the time it was enacted, *it only applied to pure QMBs and not to dual eligibles.* Dual eligibles, definitionally distinct from the QMBs, were governed by 42 U.S.C. § 1396a(a)(15), which did not have any qualifier or reference to § 1396a(n). Thus, under the Secretary's explanation of § 1396a(n), the pure QMBs would be subject to this discretionary cap, while the dual eligibles would not be. There is no logical reason for such a distinction, and we find no explanation in the legislative history to support such a differentiation. Under the Association's approach, on the other hand, it is hard to explain why the states needed permission to break the Medicaid fee cap for QMBs when Congress didn't apparently think before this time that such permission was needed for dual eligibles. Neither interpretation is particularly satisfying.

What both have in common, however, is what appears to be an erroneous assumption about the difference to which the statute actually refers. Both parties

assume that the § 1396a(n)'s language, "eligible individuals who are not qualified medicare beneficiaries," means that the statute is saying that the State may pay more for QMB payments under Part B than it pays for regular Medicaid payments for the same service. Thus, the comparison is Medicare Part B versus Medicaid. But "*eligible individuals* who are not qualified medicare beneficiaries" refers more logically to *dual eligibles.* This understanding of the statute suggests simply that the State may pay more for QMB payments under Plan B than it pays for dual eligibles under Plan B. While somewhat incongruous on first impression, the complicated statutory provisions of Medicaid explain this rule. While it appears that the state must pay *all* of the copayment and deductible under the Medicare cost-sharing definition for QMBs (with a small caveat, discussed below), under the dual eligible provision the state is allowed to impose a small charge to the beneficiary if it chooses not to pay the whole amount, as discussed in part II.A, *supra.* If a state exercised that option, it would be paying more for the QMB than for the dual eligible, and this provision appears to be merely stating that that is an allowable situation.

This approach is further confirmed by referring to the other provision to which the QMBs were "subject." Without getting into much detail, 42 U.S.C. § 1396o relates to a state's ability to impose certain charges on certain plan participants for certain services. It allows for "nominal" charges, in the form of "deductions, cost sharing, or similar charge" to be made to QMBs for their Medicare Part B coverage through the Medicaid plan. This section provides greater harmony between the dual

eligibles, who were covered totally or at a lower amount where the lower amount was keyed to income and resources, and QMBs, who could, under § 1396o, be charged some nominal amount. Because the amounts of nominal charges in either category were not necessarily set at the same levels, § 1396a(n) simply allowed for the situation where the QMB was charged less than the dual eligible, so that the state paid more for QMBs.

The legislative history of these 1986 provisions indicates in strong terms that Congress did not view the QMB provision to allow the state to pay only some portion of the copayment amount. In outlining the scope of the QMB program, the House report indicated that "States would be permitted to pay just for the Medicare Part B premium and the other Parts A and B cost-sharing requirements for Medicare beneficiaries." H.R. Rep. No. 727, 99th Cong., 2d Sess., reprinted in 1986 U.S.C.C.A.N. 3607, 3695. While the surrounding paragraphs were designed to explain how limited the states' responsibility was for this program (which was being billed as a cheaper alternative than expanding Medicaid), and explained other ways the program was modest in character ("States would determine whether they wished to offer this assistance and, if so, where to set the income eligibility standards," *id.*), it did not note that the State contribution could be discretionarily limited as well, certainly a strong selling point when attempting to emphasize the limited nature of the new option.

Perhaps more tellingly, the House report contains an extended discussion of the payment mechanics under this provision that contemplates a number of hypothetical

situations, none of which include the state paying less than the whole 20%:

> For elderly and disabled individuals whom the State chose to cover, *the Medicaid program would pay for the Part B deductible and the beneficiary's 20 percent coinsurance on Part B services.* If the beneficiary uses a physician who takes assignment, Medicaid would pay the physician directly *for the 20 percent coinsurance* and the patient could not be billed for any amounts above the Medicare reasonable charge. However, if the physician elects not to take assignment, the beneficiary would submit the claim for the 20 percent coinsurance requirement to the State Medicaid program and would be liable for *an additional amount* charged by the physician. The Committee therefore encourages the States to make available to the elderly and disabled assisted under this provision a list of physicians in their communities who will agree to accept assignment.

Id., 1986 U.S.C.C.A.N. at 3696 (emphasis supplied). The language clearly evinces a desire by the Committee to protect the eligible individuals; its discussion certainly would have noted their possible liability for part or all of the 20% if such liability existed. Thus, neither the discussion of the bill explaining the limited additional burden QMB buy-ins would pose, nor the discussion of the payments required of the QMBs themselves, mentions the possibility that this provision would allow the state to pay less than the full 20%; in contrast, the language overwhelmingly suggests that the full amount *must* be paid.

D.

In 1988, Congress acted thrice with respect to the buy-in program. First, it made the QMB buy-in provision mandatory rather than optional by striking out "at the option of the State" from the beginning of 42 U.S.C. § 1396a(a)(10)(E). Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 1988 U.S.C.C.A.N. (102 Stat.) 683, 748.[8] At the same time, it expanded the definition of QMBs by increasing the maximum income level (to 100% of the poverty line, with no option for the states to set the eligibility line lower) and resource amount (from one to two times the supplemental security income program maximum). *Id.* § 301(b), (c), 1988 U.S.C.C.A.N. (102 Stat.) at 748-49.

That is basically all that Congress did on its first consideration of the matter.[9] The House Report accompanying the bill, however, goes far beyond a simple explanation of these minor amendments to the statute. It begins by explaining that Congress was lightening the load on state Medicaid programs by expanding the Medicare coverage of catastrophic care, and used this as its justification for imposing the mandatory QMB buy-in requirement on the States as a cost-effective use of the

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[8] According to the accompanying House Report, only one state had decided to avail itself of the optional approach created under the 1986 provisions.

[9] It also did clean up, including providing a slightly cleaner definition of what constitutes the medicare cost-sharing that the state must provide to QMBs. *Id.* § 301(d), 1988 U.S.C.C.A.N. (102 Stat.) at 749. While the definition is more elegantly drafted, it does not change the contents in any significant way except as to payments for prescribed drugs.

states' saved resources. It included language, set out in the margin, that suggested that the states' payments would cover all of the amounts of copayments.[10] Yet it then proceeded to state, in unequivocal terms, an understanding of the buy-in program such that the states did not need to pay above the Medicaid cap:

> The bill would require States to pay Medicare cost-sharing, including coinsurance, on behalf of eligible individuals. It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some States pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in

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[10] Thus, the introduction to the report stated that "States would be required to pay the Medicare premiums, deductibles and coinsurance for all Medicare enrollees with incomes at or below the Federal poverty guideline and assets at or below twice the Supplemental Security Income guidelines." H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 36, reprinted in 1988 U.S.C.C.A.N. 857, 859. Later, in describing treatment of dual eligibles, the report notes that "States also pay Medicare deductibles and coinsurance on behalf of their dual eligibles." *Id.* at 57, 1988 U.S.C.C.A.N. at 880. And in describing the effect of the new mandatory QMB buy-in requirements, it states that

> the States would be required to pay the Medicare premiums, deductibles, and coinsurance for all elderly and disabled individuals . . . . States would not be required to provide these individuals the full range of Medicaid benefits that they offer to categorically or medically needy beneficiaries; instead, they would be required only to pay Medicare cost-sharing on their behalf.

Id. at 60, 1988 U.S.C.C.A.N. at 883.

> the case of a bill where the amount reimbursed by Medicare – i.e., 80 percent of the reasonable charge – exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost. For example, assume that a physician actually charges a "buy-in" patient $60 for performing a particular procedure; that Medicare recognizes $50 as the reasonable charge; and that the State Medicaid program only pays $35 for this procedure. Whether or not the physician takes assignment, Medicare will pay only 80 percent of $50, leaving a $10 coinsurance obligation for the beneficiary. However, since the State only recognizes $35 as the fee for the procedure in question, and since the Medicare program has already paid the physician $40, the State is not required to pay any of the $10 coinsurance. If the State chooses to pay some or all of the $10, however, its cost would qualify for Federal matching payments at the regular rate for services.

Id. at 61, 1988 U.S.C.C.A.N. at 884. While we understand the meaning of this language, the difficult question is as to its effect. First, it must be noted again that the only reading of the statute that allows a state to pay less than the full Medicare copayment amount emerges from § 1396a(n); that provision, however, did not apply to dual eligibles, and as such, the understanding stated in the report is clearly not correct. Second, as noted above, these amendments that the report accompanied were quite minor, dropping out "at the option of the State" and tinkering with the parameters of the QMB population.

Thus, the actual legislation enacted was not the sort that could graft this Medicaid cap onto what was previously there. The question thus becomes whether this report language should influence the interpretation as to previous enactments. We think that it should not. This wrenching change to a statute's meaning that had been stable for 20 years points precisely to the pitfalls of relying on "post enactment legislative history," which Justice Scalia recently has characterized, quite appropriately, as an oxymoron. *United States v. Carlton*, 129 L. Ed. 2d 22, 34 (1994) (Scalia, J., concurring); *see also Periera by Periera v. Kozlowski*, 996 F.2d 723, 726-27 (4th Cir. 1993). To the usual comparison of laws and sausages a new observation must be added: as our eating habits become healthier, and less filler is added to the making of sausage, so more is added to the making of law. *See, e.g., Landgraf v. USI Film Prods.*, 128 L. Ed. 2d 229, 250-51 (1994). While once a helpful source of guidance to Congressional intent, legislative history often may lead one astray. Given the narrow changes made to the provisions in question, we believe the quoted text to be little more than an attempt to alter the balance on the second front when someone could not win on the first. It is the intent of the enacting Congress, not that of a subsequent Committee or members of its staff, that controls. *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Later in 1988, Congress again returned to the definition of a QMB. In the Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, 1988 U.S.C.C.A.N. (102 Stat.) 3342, Congress removed the requirement that a QMB not be covered under the state Medicaid program; the remaining definition thus was that the individual be

eligible for Medicare and meet the income and resource limitations. *Id.* § 8434(a), 1988 U.S.C.C.A.N. (102 Stat.) at 3805. Under this definition, essentially all dual eligibles and pure QMBs were covered.[11] Finally, in an act providing technical clean-up for the Medicare Catastrophic Coverage Support Act from earlier in the year, Congress also removed the old provision governing dual eligibles, 42 U.S.C. § 1396a(a)(15). See Family Support Act of 1988, Pub. L. No. 100-485, § 608(d)(14)(I), 1988 U.S.C.C.A.N. (102 Stat.) 2343, 2416. (Oddly, the repeal of the dual eligibles provision occurred before the expanded QMB definition was passed, so for some time there was not perfect harmony.) Thus, by the end of 1988, the QMB provision had been expanded, first to include a larger pool of "pure QMBs," and then to include the old dual eligibles, and the old dual eligibles provision was eliminated.

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[11] The House Conference Report makes this explicit:

> The conference agreement clarifies that individuals who, as of January 1, 1989, will be mandatorily eligible for coverage of their Medicare cost-sharing (qualified Medicare beneficiaries) are individuals who are entitled to Medicare, whose income meets specified standards, and whose resources do not exceed twice the amount allowed under the SSI program, whether or not they are otherwise eligible for Medicaid.

H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. 284, reprinted in 1988 U.S.C.C.A.N. 5048, 5344.

E.

In 1989, Congress revisited the area tangentially and with more problematic commentary. The problem that it was facing involved assignment. In the Budget Reconciliation Act, Pub. L. No. 101-239, § 6102, 1989 U.S.C.C.A.N. (103 Stat.) 2106, 2182, Congress required that payment for physicians' services "to any individual who is enrolled under [Medicare Part B] and eligible for any medical assistance (including as a qualified medicare beneficiary . . .) with respect to such services under a State [Medicaid plan] may only be made on an assignment-related basis." This prevents physicians from charging above the Medicare rate for the new expanded QMB community. The House report that accompanied the bill continues to indicate an awareness of states applying the Medicaid cap in Medicare reimbursement. After noting that up until this point, dual eligibles are effectively covered by the Medicaid assignment rule, the report notes that "[t]he Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question." H.R. Rep. No. 247, 101st Cong., 1st Sess. 364, reprinted in 1989 U.S.C.C.A.N. 1906, 2090. Describing the effect of the new provision, the report notes that "[i]t does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims." *Id.*

Once again, we are faced with difficult legislative commentary that contradicts the settled understanding of the statute's provisions while not enacting provisions that

could in any way alter or affect the substantive provisions discussed in the commentary. Once again, we feel that fidelity to what Congress actually passed, and not what the report later attempts to explain is allowed, requires us to discard this post-enactment material.

From 1965 through 1986, Congress established a framework, incrementally expanded, under which the substantive provisions were developed and amended. Our reading of the statute, and the contemporaneous legislative history, discloses to us clear Congressional intent that state copayments under the buy-in program for either dual eligibles or pure QMBs be, except for optional nominal charges under § 1396a(a)(15) or later § 1396o, complete. Whatever ambiguity appears facially in reading the provisions in question, and we do not believe there to be much for those willing to plunge into the morass, does not remain once the contemporaneous legislative history is examined. While it may be that some in Congress, or on its staff, have had a subsequent change of heart regarding the matter, the only honest way to change the law is to actually change the law, not to drop contrary language into committee reports addressing totally unrelated provisions.

IV.

While it is not our duty as judges to establish policy but rather simply to use established tools of statutory construction to determine the meaning of the laws passed by others, we note that the result reached above is in accord with all common sense. While such harmony is not a prerequisite to the law, it is a serendipitous benefit

when it occurs, particularly in a statutory framework as complex as the one with which we are here involved.

As noted at the outset, our central task is to understand whether the present QMB buy-in program should be characterized as being primarily a Medicare program or a Medicaid program, and we believe that a careful reading of the statute's evolution and related legislative history discloses that Congress, at all relevant points, viewed this plan as a straightforward extension of the Medicare program to Medicare Part B eligible individuals who were too poor to buy their way into this supplemental insurance program. In our view, it makes far more sense to call this a Medicare program that is being partly paid for with Medicaid funds rather than to call it a Medicaid program backing up federal Medicare program payments. Because the program covers pure QMBs, who definitionally are not eligible for regular Medicaid coverage, it is hard to say that this scheme is a Medicaid program when it includes such non-Medicaid-covered parties. Outside of the Medicare buy-in context, pure QMBs have no involvement with Medicaid whatsoever; they fall outside the income eligibility program, and, absent the statutory command to the states to expend Medicaid funds to purchase Medicare coverage for them, the states would not expend health care funds on them. Thus, it seems somewhat anomalous to say that this is a Medicaid program that includes people who are not otherwise eligible for Medicaid.

It also seems odd to call this a Medicaid program because in many instances the 80% federal reimbursement under Medicare is higher than the Medicaid fee cap, so that the amount reimbursed under Virginia's present

plan is set not by the *Medicaid* figure but rather by *80% of the Medicare figure.* Thus, if it is a Medicaid statute, it is one with both different participants and different reimbursement rates than the "normal" Medicaid program of the state.

Finally, it could be seen as a statute with Medicare as the primary payor and Medicaid as the payor of last resort. The problem with this approach is that it would make sense if the full Medicare amount were less than the Medicaid amount, so that we could say that the Medicare amount has been paid in full, and the Medicaid funds need not kick in. But that is not the case, and the figure used is not the full Medicare amount but rather the 80% federal payment amount. Under this conception, it is a Medicare statute with different, lower rates than the "normal" Medicare program.

Given all these complexities, it seems much more comprehensible that what Congress has constructed is an extension of the Medicare program, including both Parts A and B, that requires the states to pay any and all premiums, deductibles and copayments for the elderly poor, with the exception of the nominal charges allowed under § 1396o. The federal government pays the same amount for all these participants as it does for any other Medicare participant. It seems logical to simply see this as an instance where, because of the poverty of the QMB, the state rather than the individual shoulders payment for the cost-sharing provisions of the Medicare program. While the state is expending extra money for the pure QMBs in either scenario, since absent the required buy-in program it would not have anything to do with them, the states are in a winning situation financially because they

are able to buy dual eligibles into the Medicare program, and Medicare then pays at least 80% of the cost of the beneficiary's care when many if not all of those services otherwise would be financed through the state's Medicaid funding. The only question is how good a deal the states get. Under Virginia's approach, supported by DHHS, once Virginia pays the premium and coinsurance, it is often not required to pay anything more, because the Medicaid amount is lower than the 80% federal reimbursement. Under the Association's approach, Virginia is still required to pay the 20% copayment, for which federal matching funds are also available, that the beneficiary is required to pay.[12]

It also should be noted that there is simply no way around the fact that there are going to be two tiers of repayment involved here; the only question is where the dividing line is placed. Under Virginia's approach, service for all Medicare Part B beneficiaries except QMBs is repaid at 100% of the reasonable charge under the Medicare program. Service to QMBs, on the other hand, is repaid only at the Medicaid rate or 80% of the Medicare

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[12] An outstanding question, which the Secretary tries to avoid, concerns the gap, under the Secretary's and Virginia's approach, between the state's reimbursement up to the Medicaid fee and Medicare's full reasonable charge. Under their approach, up to 20% of the Medicare reasonable charge is not paid by the states under the buy-in. Obviously, if the beneficiary is still liable for it, the entire purpose of the program is undermined. If the buy-in is treated as a Medicare program, so that the state is required to pay the full 20% difference, the question is moot.

rate, whichever is greater. Service to pure Medicaid beneficiaries is paid at the Medicaid rate. Thus, the dividing line is essentially poverty: better payment goes to those serving the eligible "rich," while worse payment comes from serving the poor of whatever age.[13] Under the Association's approach, on the other hand, the dividing line is purely age: better payment goes to providers serving those 65 or older no matter their income, while worse payment goes to the poor who are younger. Neither is a palatable choice, but it is one that we are not called upon to make: the legislative history reflects a pervasive Congressional concern with protecting the health of older Americans, and our analysis of the statute's history confirms that Congress intended to provide maximum protection to the population of Americans 65 years of age or older, and that through the buy-in program, it established a mandatory program that guarantees that indigency should not affect an individual's participation in the Medicare Part B program. We thus join both of the other circuits that have passed on this question in holding that there can be no doubt but that the QMB is a Medicare enrollee, and that payment on her behalf must be made at the Medicare rate. *Pennsylvania Medical Soc'y v. Snider*, No. 93-7775, 29 F.3d 886 (3d Cir. 1994); *New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 854 (2d Cir.), *cert. denied*, 113 S. Ct. 461 (1992).

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[13] Of course, pure QMBs are not considered "poor" by state Medicaid standards, since they do not qualify for Medicaid; this leaves the anomalous situation where the pure QMBs are eligible for Medicare coverage and not eligible for Medicaid coverage, but are treated as Medicaid patients, but not Medicare patients.

V.

Under the 1988 amendments to Virginia's state Medicaid Plan, "reimbursement will not be made directly to [rehabilitation] therapy providers for [rehabilitation] therapy services provided to Medicaid patients residing in long term care facilities . . . . " Plan Amendment 88-08. Virginia adopted this amendment based on findings that the state had, on some occasions, been paying for such services twice, once to the long term care facility and once to the rehabilitation provider. After this amendment, payment of rehabilitation providers for services rendered to pure Medicaid patients comes not from the Virginia Department of Medical Assistance Services but rather is funnelled through the long term care facilities in which the patients reside. Long term care facilities receive a per diem payment for each Medicaid patient, and the payment to the rehabilitation service providers is bundled into that block payment. As to pure Medicaid patients, the Association does not contest this system of financing its constituents' services.

As to QMBs, however, although the Medicare reimbursement amount for rehabilitation services is greater than is that under Medicaid, there is no differentiation in the per diem reimbursement to the long term care facility based on whether the services provided are financed at the Medicare or Medicaid rate, so that the rehabilitation providers do not receive any additional reimbursement from the nursing homes for QMBs, thus vitiating the providers' right to receive the full reasonable charge for their services under Medicare. The Association points out that the rehabilitation services providers receive *direct payment* from the federal government to cover 80% of the

Medicare Part B reasonable charge for services they provide to QMBs. Under the current scheme, however, which theoretically bundles the 20% copayment into the per diem amount the state pays to the nursing facilities, the service providers effectively receive nothing. The Association argues that payments for QMB services are Medicare payments rather than Medicaid payments, that the long term care facility is a stranger to the relationship, and that they are entitled to receive payment directly under the statute, rather than bundled through the nursing facilities as is the practice with pure Medicaid patients.

With respect to "pure" QMBs, such a bundling policy is not applicable. Pure QMBs are not "regular" Medicaid patients, and the hospital per diem simply does not encompass them. They are not considered "Medicaid patients" for these purposes. The Secretary seems, at least implicitly, to acknowledge this conclusion. See Br. for the Secretary of Health and Human Services, at 29-30.

The Secretary argues that as to dual eligibles, however, bundling is allowable. In support, it cites to 42 U.S.C. § 1396a(a)(32), which requires that a state plan must "provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service," with only a few exceptions not relevant here. From this it argues that the nursing facility can be considered to be the institution providing such care or service, so that payment directly to the nursing facility is allowable. In support, it cites to the *Medicaid statute* and regulations that require that

nursing facilities provide such services to Medicaid residents through their own employees or through an arrangement with an outside rehabilitation agency. 42 U.S.C. § 1396r(b)(4)(A)(i).

As an initial matter, we note first the logical fallacy in the Secretary's analysis: just because one is required to see that service is provided does not make one the provider of the service. While the long term care facility is required to provide certain service under the Medicaid Act, it is not, in fact, the actual provider of the services in question. In fact, the federal government's payments are made not to the nursing facility but rather to the rehabilitation service providers directly. While the nursing facility may be required to provide the service under the Medicaid Act, in this instance it contracts with these third parties who "provide" the service.

Beyond this, our principal problem with the Secretary's analysis is that it relies too heavily on the premise that, as with the pure Medicaid patient, it is Medicaid, not Medicare, service that is involved here. As to the pure QMB population, the rehabilitation services that they receive from Association members are not "Medicaid services" because they are not Medicaid-eligible except insofar as the state is required to buy them into Medicare as a condition of its participation in the Medicaid program. As to the dual eligibles, who are both Medicare and Medicaid patients, the characterization is similarly difficult. While it is convenient that the Medicaid statute requires services similar to those being reimbursed here under Medicare, if such services were not required under Medicaid the Secretary's reasoning would fail because there would be no way to say that the nursing facility is

required to provide them. The particular facts of this case thus cloud the picture to some extent: it is helpful to understand the fact that, in a situation in which Medicaid does not cover a certain service but Medicare does, the reimbursement is to the provider; the only characterization of the payment can be as a Medicare reimbursement. The Medicaid statute does not govern who the "provider" is in such circumstances, nor should it govern here. While the fact that these rehabilitation services are required under Medicaid means that the nursing facilities satisfy their Medicaid requirements, it is difficult to understand how that affects the characterization of the funding of these services or who is deemed the provider.

Virginia makes a similar argument, and it highlights the problem more acutely: it states that "Virginia recognizes no one as a Medicaid provider unless he has executed a written provider agreement with the Virginia Department of Medical Assistance Services." Br. of Appellant Kozlowski at 12. From this premise, Virginia argues that, since the Association's members do not have provider agreements, they cannot receive funds directly. Applying this theory generally suggests that *any* health service provider of whatever type who provides *Medicare Part B* services to QMBs will not be eligible for reimbursement of the 20% copayment from Virginia unless she also has executed a written *Medicaid* provider agreement with the state. Thus, under this approach, a provider who does not participate in both the Medicare and Medicaid programs, or who for whatever reason has not signed a written agreement with the State, cannot receive reimbursement of the Medicare Part B copayment because she is not a Medicaid eligible service provider.

Simply speaking, this approach makes no sense, and converts a simple 20% copayment into a bureaucratic nightmare. Thus, while neither the Secretary's nor Virginia's argument causes many concerns when simply approached on the particular facts of the case, a full understanding of the inadequacy of each when viewed from a more general perspective undermines their analytic soundness. It seems largely irrelevant that the nursing facility is required to provide these services under *Medicaid;* the fact of the particular arrangement under Medicaid should not be of import in deciding whom to reimburse for Medicare procedures.

We are left to determine how Virginia appropriately complies with the requirement of 42 U.S.C. § 1396a(a)(32) that it not pay "for any care or service provided to an individual . . . to anyone other than such individual or the person or institution providing such care or service." Although Medicaid funds are in question, they are being used to pay the Medicare Part B copayment for services provided under the Medicare Act. As such, the proper approach looks not to the *Medicaid* statute but rather to the *Medicare* statute to determine who is the appropriate entity for payment.[14] After the 1989 amendments, payment under Medicare Part B for "physicians' services" for

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[14] Because the appropriate statute is the Medicare Act rather than the Medicaid Act, we find it unnecessary to consider the arguments both sides make concerning the First Circuit's analysis as to the appropriate "provider" under the Medicaid Act in *Danvers Pathology Associates v. Atkins,* 757 F.2d 427 (1st Cir. 1985). That case did not involve either dual eligibles or QMBs, and was strictly confined to an interpretation of the Medicaid statute.

all QMBs may only be made on an assignment-related basis. 42 U.S.C. § 1395w-4(g)(3)(A). Physicians' services are defined to include the type of rehabilitation services involved here. *Id.* § 1395w-4(j). They are considered "outpatient physical therapy services" under 42 U.S.C. § 1395x(p), which are services "furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency." As rehabilitation agencies, the plaintiff's members fall within this definition and receive payment directly from Medicare carriers. They are the direct billers and should be the direct payees. This reasoning harmonizes the Medicaid requirement that payment only be made to the individual or service provider by finding that, as to Medicare reimbursement, it is the Medicare statute that governs whether the rehabilitation agency should be considered a service provider. Under that statute, the rehabilitation providers are the "providers" of services, not the long term nursing facilities in which the patients reside.

VI.

For the reasons stated above, we are of the opinion that the judgment and order of the district court should be, and hereby are, affirmed.

AFFIRMED

NIEMEYER, Circuit Judge, concurring in part and dissenting in part:

I concur with the rulings made in Part II of the majority opinion but with respect to the majority opinion's interpretation of the Medicare and Medicaid

statutes, I respectfully dissent. I find myself in full agreement with the opinion's characterization of the statutes that:

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Slip. op. at 9-10. Yet, after engaging in that "dense reading of the most tortuous kind" and parsing these statutes for their meaning, I reach a different result.

While the majority opinion has courageously embarked on a survey of the amendments and legislative history of the Medicare and Medicaid statutes during the last 30 years and has striven to put forward a logical explanation for the various inconsistencies it identifies, it nevertheless admits in several places where two or more interpretations are possible that "[n]either interpretation is particularly satisfying." *Slip op.* at 18. Moreover, the majority opinion fails, in my judgment, to address satisfactorily the plain language of the core provisions that we must construe, i.e. 42 U.S.C. §§ 1396a(a)(10)(VIII) & 1396a(n), and totally disregards legislative history developed during the 1988 and 1989 amendments.

The majority concludes erroneously, I submit, that because it can string together *a* reading of the text which supports its position, it has proven that "Congress has directly spoken to the precise question at issue," and thus satisfied the first inquiry under *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1984). In fact, I have reached the conclusion that there is another interpretation of the statutes, a hybrid of the majority's and the Secretary's, which has the most textual support and is more consistent with the overall regulatory scheme. But even this more convincing reading of the statute does not, I acknowledge, leave one confident that every ambiguity is resolved. In the end, I find that the most appropriate judicial response is to conclude that Congress has not spoken directly and unambiguously to the issue before us and that therefore we must defer to the interpretation of the agency charged with interpretation and enforcement of the statutes. Indeed, the fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer. Because the Secretary's reading of the statute, though different from my own, is nonetheless a reasonable and therefore a permissible one, I would defer to the agency and reverse the judgment of the district court.

I

To begin with some background which may lend understanding to the more esoteric provisions at issue, I note that this case involves the interplay of two separate federal health care programs originally enacted in 1965,

the Medicare Act, 42 U.S.C. §§ 1395-1395ccc, and the Medicaid Act, 42 U.S.C. §§ 1396-1396v. Medicare is an insurance program, funded and operated by the federal government, for those over the age of 65 and for those with specified disabilities. Medicare's coverage is divided into two parts. All eligible individuals who opt to participate in the program are entitled to benefits under Part A, which provides limited protection against the costs of certain hospital and related post-hospital care, home health service, and hospice care. 42 U.S.C. § 1395c. Under Part B, eligible individuals may purchase supplemental insurance for more extensive health care benefits, including coverage for physician and out-patient services. Once an individual who chooses to enroll in Part B pays the appropriate premium and annual deductible, the federal government then pays 80% of what it determines to be the reasonable costs of covered services, leaving the individual responsible for paying the remaining 20%, known as the "coinsurance" payment. 42 U.S.C. §§ 1395l & 1395cc(a).

The Medicaid program, in contrast, is funded and operated by both the federal and state governments and its availability is based upon financial need, irrespective of age. Each state sets its own criteria for financial need, and in most cases the state threshold is less than the federal poverty level. A state is not required to participate in the program, but once it decides to do so, it must comply with a wide range of federal statutes and regulations. 42 U.S.C. § 1396c. Each participating state must develop its own Medicaid plan, establishing a schedule of payment rates and methods for different types of medical services, 42 U.S.C. § 1396a(a), and the plan must be

approved by the Secretary of the Department of Health and Human Services, 42 U.S.C. § 1396a(b). Those providing services to Medicaid patients must accept the established Medicaid rate as payment in full and may not demand additional payment from the patients themselves. 42 U.S.C. § 1320a-7b(d). In virtually all cases, the approved Medicaid rate is less than the reasonable charge permitted under the Medicare Act. Depending upon the circumstances of the medical services, the federal government will reimburse the state between 50% and 83% of the cost of the services. 42 U.S.C. § 1396d(b).

Many individuals, who are both poor *and* either elderly or disabled, qualify for both Medicare and Medicaid and are therefore known as "dual-eligibles." Because many of these individuals cannot afford to pay Medicare Part B premiums and because of the advantages of participation in the Part B program, the Medicaid Act has always permitted states to use Medicaid funds to enroll these "dual-eligibles" in Part B coverage. In 1986, Congress created a second class of persons eligible for Medicaid-financed participation in Part B of the Medicare Program, authorizing such coverage for those who, while not poor enough to qualify for Medicaid, nevertheless had incomes below a modest level set by the state, but not exceeding the federal poverty line. *See* 42 U.S.C. § 1396d(p)(1). Those made eligible to participate in 1986 were referred to as "qualified medicare beneficiaries" or "pure QMBs."[1] While the 1986 version of the Medicaid

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[1] In keeping with the terminology of the majority opinion, I will refer to those who met the 1986 definition of "qualified medicare beneficiary" as "pure QMBs." As noted, *infra*, in 1988

Act gave states the choice whether to enroll pure QMBs in Part B of the Medicare Program, a 1988 amendment to the Medicaid statute made such enrollment mandatory by deleting the words "at the option of a State" from 42 U.S.C. § 1396a(a)(10)(E).

Thus, the question presented in this case is not *whether* states are required to use Medicaid monies to enroll dual-eligibles and pure QMBs in Part B (because clearly they are required to do so), but whether they are required to pay *all* of the costs associated with Part B *in full*; or, stated otherwise, whether it would be consistent with the Medicaid Act for the states to cap their coinsurance and annual deductible payments at the approved Medicaid rate (or some other amount less than 100 percent) for a given item or service. As of January 1, 1991, Virginia began paying coinsurance and deductibles only to the extent that the Medicaid rate would pay for the services. In response, plaintiff Rehabilitation Association of Virginia, an organization representing providers of rehabilitation services in Virginia, brought this action to compel *full* payment of coinsurance and deductibles under Part B of the Medicare Program for all qualified Medicare beneficiaries, including dual-eligibles and pure QMBs.

In support of its position, the Rehabilitation Association relies on 42 U.S.C. § 1396a(a)(10)(E), which requires

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Congress changed the official definition of "qualified medicare beneficiary" to encompass both pure QMBs *and* dual-eligibles. To avoid confusion, I keep the terminology of the two mutually exclusive classifications – dual-eligibles and pure QMBs – distinct throughout.

that the state Medicaid plans provide "for making medical assistance available for medicare cost-sharing (as defined in Section 1396d(p)(3) of this title) for qualified medicare beneficiaries," with certain exceptions. Section 1396d(p)(3), in turn, defines "medicare cost-sharing" to include Medicare premiums, deductibles and coinsurance. According to the Rehabilitation Association, 42 U.S.C. § 1396a(a)(10)(E), in combination with the definition of "medicare cost-sharing" in 42 U.S.C. § 1396d(p)(3), should be read to require payment in full for all of these medical costs, thus prohibiting states from capping their payments at any amount less than 100 percent. The Rehabilitation Association notes that two other circuits have adopted this position. *See Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994), and *New York City Health & Hospitals Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992) (by divided vote, with dissenting opinion). *But see Haynes Ambulance Service, Inc. v. Alabama*, 820 F. Supp. 590 (M.D.Ala.1993) (reaching opposite result), *rev'd and remanded*, ___ F.3d ___, No. 93-6419 (11th Cir. Nov. 1, 1994).[2]

The United States Secretary of Health and Human Services and the Commonwealth of Virginia argue that the requirement that the state Medicaid plans make available funds for Medicare Plan B premiums, deductibles and coinsurance should not be read to mandate that such

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[2] Subsequent to the argument of this case, the Eleventh Circuit issued an opinion essentially adopting the position of the Second and Third Circuits in *Perales* and *Snider*, reversing the Alabama district court.

funds provide 100 percent reimbursement of the Medicare rate, but rather that payment may be made for Medicare services at the generally lesser *Medicaid* rate of reimbursement. They contend that the statutory provisions cited by the Rehabilitation Association address only the *requirement* that Medicaid funds be available for Medicare coinsurance payments and deductibles but not the *amount* of payment. They argue that the *amount* of these medical payments is set forth in a separate provision, 42 U.S.C. § 1396a(n), entitled "Payment Amounts." That section *permits* a state to pay beyond the Medicaid rates, but does not mandate it. Section 1396a(n) provides that state plans for QMBs

> *may* provide payment in an amount that respect to the service or item that results in the sum of such payment and any amount of payment made under [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State [Medicaid] plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(Emphasis added). According to the Secretary and Virginia, there would be no reason to use the permissive verb form "may provide" in § 1396a(n) if § 1396a(a)(10)(E) and § 1396d(p)(3) *mandated* payment in full at the Medicare rate. The Secretary argues further that, even if we disagree with her interpretation, the relationship of the various sections at least creates an ambiguity. Therefore, she argues we should uphold her position for the independent reason that Congress has vested the responsible agency with the authority to interpret the two acts.

Relying largely upon the logic of the Second Circuit's decision in *Perales*,[3] the district court granted summary judgment to the Rehabilitation Association, and the Secretary and Virginia noticed this appeal.

For the reasons that follow, I believe that neither the Secretary nor the Rehabilitation Association has the better argument. In my view, each is only partially correct. While the language and history of the statute plainly supports the Secretary's interpretation of the states' payments obligation for pure QMBs, the Rehabilitation Association provides the better reading of the states' obligation for dual-eligibles.

II

The analysis must begin with the text of the applicable provisions as they currently exist, and in particular with the core provision of the Medicaid Act which establishes and defines the contours of the state buy-in program, 42 U.S.C. § 1396a(a)(10)(E). The provision requires states that participate in the Medicaid program to make Medicaid monies available for "medicare cost-sharing" as defined in 42 U.S.C. § 1396d(p)(3). The definition of "medicare cost-sharing" in § 1396d(p)(3) lists four categories of costs, including premiums, deductibles and coinsurance payments, for which patients covered by

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[3] The majority opinion, in affirming the district court's judgment, does not rely, quite properly I believe, upon the argument raised by the Rehabilitation Association and relied on by *Perales* that the Secretary's policy violates the Medicare Act by denying to health care providers the full reasonable value of their services.

Medicare Part B are normally held responsible. Reading § 1396a(a)(10)(E) and § 1396d(p)(3) in a vacuum, one might conclude, as the majority opinion does, that they combine to mandate that states use Medicaid funds to provide reimbursement for the *full* amount of *all* costs associated with Medicare Part B, including the full amounts of deductibles and coinsurance.

But the majority's conclusion cannot be maintained in the presence of the exceptions clause attached to § 1396a(a)(10)(E), which states:

> except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) . . . who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing . . . , *subject to the provisions of subsection (n) of this section*. . . .

42 U.S.C. § 1396a(a)(10)(VIII) (emphasis added). The exceptions clause directs attention to a separate provision in § 1396a entitled "Payment Amounts," which specifies the amount of payments that a state must make under the Medicaid program for Medicare cost-sharing. *See* 42 U.S.C. § 1396a(n). That provision uses the permissive language "may" to *allow* states to make coinsurance payments for QMBs above the approved Medicaid rate, thus implying that state plans are equally free *not* to make payments above the Medicaid rate. The role of § 1396a(n) is simply to authorize, but not require, the states to pay an amount in excess of the Medicaid rates for that class of QMBs described in Exception VIII.

I find no difficulty in rejecting the Rehabilitation Association's reading that the § 1396a(n)'s sole purpose is to clarify that states are indeed *permitted* to do what § 1396a(a)(10)(E) *requires* them to do. Even the majority opinion concedes that this reading is not "particularly satisfying," since the Rehabilitation Association fails "to explain why the states needed permission to break the Medicaid fee cap for QMBs when Congress didn't apparently think before this time that such permission was needed." *Slip op.* at 18. One is hard pressed to explain why Congress would make an action mandatory for states in one section and still feel the need to clarify, in a separate section linked to the first by the words "except that," that the states had permission to follow Congress' mandate.

I agree with the Secretary that the plain language of § 1396a(n) requires a reading that states *may* provide payment in amounts exceeding those otherwise mandated under the Medicaid statute. But what neither the parties nor the majority acknowledges is that the authorization given by § 1396a(n) applies only to *pure* QMBs and not to dual-eligibles. The plain language of Exception VIII, quoted above, demands this conclusion. That clause, which directs the reader to § 1396a(n), explicitly limits its own operation to cases where a state gives medical assistance to "a qualified medicare beneficiary . . . *who is only entitled to medical assistance because the individual is such a beneficiary.*" 42 U.S.C. § 1396a(a)(10)(VIII) (emphasis added). Congress added the highlighted language in 1988, in the same bill in which it expanded the definition of "QMB" to cover both pure QMBs and dual-eligibles. *See* Technical and Miscellaneous Revenue Act of 1988,

Pub. L. No. 100-647, §§ 8434(a), 8434(b)(1), 102 Stat. 3342, 3805. And pure QMBs, who are by definition ineligible for Medicaid, are *only* "entitled to medical assistance" (i.e. Medicaid monies) because they are considered "qualified medicare beneficiaries." By contrast, dual-eligibles *are* otherwise entitled to medical assistance because they are otherwise eligible for the entire panoply of Medicaid benefits. By taking pains to add this language, Congress intended to continue treating the payment obligations of the two groups differently, despite combining them into a single definitional category for other purposes.[4]

Distinguishing the treatment of QMBs and the treatment of dual-eligibles is consistent with the approach Congress took before 1988. When enacted in 1986, § 1396a(n) applied only to pure QMBs. By adding to Exception VIII the qualifying clause highlighted above in 1988, Congress manifested its intent that § 1396a(n) remain applicable only to pure QMBs. That Congress wished to continue treating pure QMBs and dual-eligibles differently is not surprising given the fact that the two groups are not similarly situated. Indeed, dual-eligibles are by definition *poorer* than pure QMBs, and thus I think the scheme most in line with Congressional intent is the

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[4] Interestingly, the recent Eleventh Circuit opinion is the only other opinion which has acknowledged this crucial piece of language which Congress inserted into the exceptions clause in 1988. *See Haynes*, ___ F.3d ___, at ___. The *Haynes* court agrees that this language is intended to distinguish pure QMBs from dual-eligibles, but then fails, without explanation, to follow through on its observation and recognize the implication that the exception clause's reference to "subsection (n)" is meant only to apply to pure QMBs.

one in which the states may ask for a greater financial contribution from the group that is better able to contribute.

Additional textual support for this interpretation is provided by two provisions which the majority puzzlingly overlooks. The first is the "part or all" language in Exception II, also attached to § 1396a(a)(10)(E). *See* 42 U.S.C. § 1396a(a)(10)(II). This clause states that "provision for meeting *part or all of the cost* of deductibles, cost sharing, or similar charges under [Medicare Part B] . . . for individuals eligible for benefits under such part, shall not . . . require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals." 42 U.S.C. § 1396a(a)(10)(II) (emphasis added). This language shows that Congress contemplated that states might provide only a portion of the costs associated with enrolling individuals in Medicare Part B. This militates against the majority's and the Rehabilitation Association's insistence that the Medicaid Act mandates that states provide all costs, in full.

Second and even more convincing is the existence of a provision which limits the imposition of cost-sharing charges on qualified Medicare beneficiaries to certain "nominal" amounts, as defined by the Secretary's regulations. *See* 42 U.S.C. § 1396a(a)(14) (requiring that enrollment fees, premiums, deductions, cost sharing, or similar charges, may be imposed under state Medicaid plans only as provided in section 1396*o*); 42 U.S.C. § 1396*o*(a) (with some exceptions, requiring that "any deduction, cost sharing, or similar charge" imposed on qualified Medicare beneficiaries be limited to a "nominal" amount

as defined by regulation, or "twice the nominal amount" for non-emergency services received in a hospital emergency room). Without determining the definition of "nominal," it is sufficient to identify these sections as further and convincing proof of Congress' expectation that states would not always provide 100 percent reimbursement for the patients they enrolled in Medicare Part B insurance. These provisions, requiring that any such costs imposed on QMBs be "nominal," would be rendered mere surplusage if the majority's opinion were correct because the majority believes that QMBs should never have to pay such nominal costs. I hasten to add, however, that if my interpretation were to be adopted by the Secretary and imposed on the states, states such as Virginia would no longer be able to cap their contributions at the Medicaid rate, where the difference between the state Medicaid rate and 100 percent of the federal Medicare fee was more than "nominal."

To summarize, then, the Medicaid Act's core buy-in provision, § 1396a(a)(10)(E), together with the definition of cost-sharing in § 1396d(p)(3), if read in a vacuum, might be interpreted to mandate that the states cover the *full* amount of *all* the costs associated with Medicare Part B. But, as I have already pointed out this is a faulty interpretation in light of Exception VIII, which applies only to pure QMBs. As for dual-eligibles, I can find no provision which qualifies or otherwise creates an exception to full payment of all their costs. Thus, I conclude that as to dual-eligibles, the majority and the Rehabilitation Association are correct; the states may not, given the text of the Medicaid Act in its current form, ask dual-eligibles to share the costs of Medicare Part B, including

coinsurance payments. But as to pure QMBs, the states *may* ask them to shoulder the responsibility for costs exceeding what the state would normally pay for service under its Medicaid plan, at least up to a "nominal" amount.

Confining myself solely to the statutory language, I therefore must conclude that Medicaid's core buy-in provision, § 1396a(a)(10)(E), cannot be read in a vacuum and that Exception VIII explicitly exempts one group of qualified Medicare beneficiaries, what we refer to as "pure QMBs," from the 100 percent reimbursement mandate. While participating states are authorized under the Medicaid Act to provide payment beyond Medicaid rates to pure QMBs in assisting them to participate in Medicare Part B, they are not required to do so. *See* 42 U.S.C. § 1396a(n). In certain circumstances, states may cap their levels of reimbursement at the Medicaid rates, but only if doing so leaves the patient with no more than a "nominal" cost. *See* 42 U.S.C. § 1396*o*(a)(3). As for dual-eligibles, the statute does not seem to exempt them from the 100 percent reimbursement mandate of § 1396a(a)(10)(E), and thus I agree that adequate textual support exists for this aspect of the majority's interpretation of the Act.

III

I believe that the historical treatment of the states' payment obligations for dual-eligibles and QMBs, within the framework of an evolving statutory scheme, provides further corroborative evidence of the congressional intent that I have derived from the statutory language itself. This historical treatment, which in many instances is

ambiguous, is nevertheless relevant because earlier versions of the two acts explicitly address the issues presented to us in this case.

As originally enacted in 1965, the Medicaid Act permitted states to pay on behalf of certain dual-eligibles the entire costs associated with Medicare Part B. If states chose not to make such payment in full, the Medicaid Act required that payment be made "on a basis reasonably related . . . to such individual's income or his income and resources." Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(15), 1965 U.S.C.C.A.N. 305, 373 (codified prior to repeal at 42 U.S.C. § 1396a(a)(15)). Thus, a state which chose not to pay the entire Medicare Part B insurance for dual-eligibles was nonetheless responsible for a portion of the payment, but the portion for which it was responsible bore no relation to the Medicaid rate.

In 1986, Congress decided to create a second class of persons eligible for Medicaid-financed enrollment in the Medicare Part B insurance program. Specifically, it gave the states the *option* of enrolling in Medicare Part B certain individuals – pure QMBs – who were not poor enough to be eligible for Medicaid but still had income and resources below a defined level. Omnibus Budget Reconciliation Act of 1986 ("OBRA"), Pub. L. No. 99-509, § 9403(b), 100 Stat. 1874, 2053-54 (codified as amended at 42 U.S.C. §§ 1396a(a)(10)(E) & 1396d(p)(1)). Significantly, Congress treated the states' payment obligations to each of the two groups who were eligible for the buy-in program separately and distinctly. Instead of simply extending the means test of old § 1396a(a)(15) to pure QMBs, Congress explicitly excluded pure QMBs from application of that subsection, leaving the means test to apply only to

dual-eligibles. *See* OBRA § 9403(g)(4)(A), 100 Stat. 2056 (amending § 1396a(a)(15) prior to its repeal).[5]

What Congress intended in 1986 as a substitute for the means test for pure QMBs is the key to this case. For in 1986 Congress enacted essentially the same network of provisions governing the payment obligations for states which opted to buy-in pure QMBs as exists today, with two caveats: today, (1) states are *required* to buy-in pure QMBs, and (2) the definition of "qualified medicare beneficiary" has been expanded. But as for the *amount* of a state's payment obligation, the exact same textual analysis I applied to the current statutory scheme also applies to the statutory language as it existed in 1986. To summarize that analysis, while the definition of Medicare cost-sharing included a list of all of the costs associated with Medicare Plan B, the definition was immediately followed by an exceptions clause which stated that the

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[5] In 1986, Congress amended § 1396a(a)(15) by inserting "are not qualified medicare beneficiaries" after "older who." Thus, prior to its repeal in 1988, § 1396a(a)(15) required a state Medicaid plan to –

> In the case of eligible individuals 65 years of age or older *who are not qualified medicare beneficiaries* (as defined in § 1396d(p)(1) of this title) but are covered by either or both of the insurance programs established by [Medicare], provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by [Medicare] is not met, the portion thereof which is met shall be determined on a basis reasonably related . . . to such individual's income or his income and resources.

(Emphasis added).

states *may provide* costs in an amount exceeding the Medicaid rate, implying clearly that states were not *required* to provide the *full* amount of all the costs.[6]

The majority opinion is hard pressed to come up with an alternative reading of these provisions as they were passed in 1986. The majority, as I noted above, is highly skeptical, and justifiably so, of the Rehabilitation Association's position that Exception VIII merely clarifies that the states have permission to do what the Act requires them to so. Recognizing the weakness of the Rehabilitation Association's position, the majority attempts to derive a third interpretation, consistent with its position, by closely analyzing the wording of § 1396a(n). In that section, states are told that they "may provide" payments for services for QMBs through the buy-in program in excess of what is "otherwise payable under [Medicaid] for the item or service *for eligible individuals who are not qualified medicare beneficiaries*" (emphasis added). The natural reading of the quoted phrase is that it compares the amount paid for pure QMBs under Medicare Part B with the amount paid normally for Medicaid patients under the state Medicaid plan, indicating that the former *may* exceed the latter. The majority chooses instead to read it as comparing the amount paid for pure QMBs under Medicare Part B with the amount paid for dual-eligibles under Medicare Part B.[7] "This understanding of the statute suggests simply that the State may pay more for

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[6] The same additional textual supports outlined above also existed in 1986. *See* 42 U.S.C. §§ 1396a(a)(10)(II), 1396a(a)(14), and 1396*o*(a).

[7] The majority achieves this interpretation by reading "eligible individuals" to mean (i) individuals eligible for the

[pure] QMB payments under Plan B than it pays for dual eligibles under Plan B." *Slip op.* at 18-19.

The majority's position is unconvincing for several reasons. First and foremost, the reading suggested by the majority, like that of the Rehabilitation Association, would result in a system where the states would be required to make *larger* payments for pure QMBs than for dual-eligibles, while, by definition, dual-eligibles are *poorer* than pure QMBs. I would agree with the majority (though with less understatement) that this notion seems "somewhat incongruous." *Slip op.* at 18-19. For it is wholly unclear to me why Congress would create a system forcing dual-eligibles to contribute to their coinsurance payments, while the states would be required to pick up the entire cost of coinsurance for pure QMBs. One cannot simply state that this was an unintended anomaly of the new statutory regime, because, as noted above, the 1986 amendments specifically excluded pure QMBs from application of old § 1396a(a)(15). If Congress intended that the states have a different payment obligation for pure QMBs than for dual-eligibles, as it clearly did, the rational inference is that Congress intended that states have a lesser obligation for pure QMBs.

Second, it makes little sense to read the requirement that states "mak[e] medical assistance available for medicare cost sharing," 42 U.S.C. § 1396a(a)(10)(E), to require

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buy-in program, rather than (ii) individuals eligible for Medicaid. Thus, "eligible individuals who are not qualified medicare benficiaries" would refer logically to the other category of patients who are eligible for the buy-in program, namely dual-eligibles. *See slip op.* at 18-19.

full payment of coinsurance for pure QMBs when that subsection, when it was drafted in 1986, allowed such payments "at the option of a State." *See* OBRA § 9403(a)(3), 100 Stat. 2053. If a state had the option of deciding whether or not it would even pay Medicare Part B premiums for pure QMBs at that time, one must assume that it *also* had discretion as to the *amount* of coinsurance that it would pay.

Third, the majority's textual analysis of § 1396a(n) raises more questions than it answers and is subject to the same criticism that the majority applies to the Rehabilitation Association's reading of that provision. If, as the majority believes, the 1986 version of the Act contained one section which clearly allowed states to provide less than 100 percent reimbursement for dual-eligibles according to a needs-based standard, and another section which clearly mandated 100 percent reimbursement for pure QMBs (i.e., the all-or-nothing option), § 1396a(n) would be rendered mere surplusage. It is utterly implausible, I submit, to believe that Congress would create a new section in the Act solely to acknowledge that it is permissible for states to do what Congress *requires* them to do in other sections.[8]

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[8] The Majority's textual analysis is also technically flawed because it would create a glitch in the *current* version of § 1396a(n). Section 1396a(n) reads today exactly as it did in 1986. Congress has made no changes to its wording, although in 1988 it did expand the definition of "qualified medicare beneficiary." The Majority therefore presumably remains firm in its position that the phrase "eligible individuals" in section 1396a(n) refers to (i) individuals eligible for the buy-in program, rather than (ii) individuals eligible for Medicaid. *See* n.7, *supra*. Unfortunately,

Thus, I cannot conclude that the operative sections cited by the majority and the Rehabilitation Association, as enacted in 1986, required full payment of coinsurance for pure QMBs. The difficulties with the majority's and the Rehabilitation Association's reading of the 1988 amendments are apparent. If Congress did not intend for § 1396a(a)(10)(E) to require full payment for pure QMBs in 1986, how can we assume that it intended for such payment in 1988 with no statement in the statute to that effect? This would be a substantial change in the law. To assume that those new state obligations are created by implication, without some expressed indication to that effect in the statute, is a greater leap than I am prepared to make. Moreover, my interpretation of the 1986 version of the statute is fully consistent with the changes Congress adopted in 1988. Though alluded to above, it is worthwhile to once again review what the 1988 amendments actually did.[9]

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this renders the rest of the section meaningless, as the clause "eligible individuals who are not qualified medicare beneficiaries" would refer to an empty set. As of 1988, when Congress expanded the definition of "qualified medicare beneficiary" to include pure QMBs and dual-eligibles, *all* individuals eligible for the buy-in program are considered qualified Medicare beneficiaries.

Thus, I am confident that the natural reading of § 1396a(n) was correct in 1986 and is correct today.

[9] In addressing the meaning of the 1988 amendments, the Secretary urges that we consider the House Report which appears to approve limiting the coinsurance payment for QMBs to the Medicaid rate. *See* H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 61, *reprinted in* 1988 U.S.C.C.A.N. 857, 884. That report provides:

In 1988, Congress made a number of significant changes in the treatment of dual-eligibles and pure QMBs. First, it removed the phrase "at the option of a State" from 42 U.S.C. § 1396a(a)(10)(E), thus obligating states to enroll their pure QMBs in Part B of the Medicare program. *See* Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 683, 748. Also in 1988, Congress eliminated the distinction between dual-eligibles and pure QMBs by changing the definition of "qualified medicare beneficiary" to include dual-eligibles. *See* Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805.

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some states pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. *Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare – i.e., 80 percent of the reasonable charge – exceeds the amount Medicaid would pay for the same item or service.* However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

(Emphasis added). Even though that aspect of the report appears to be commenting on the practice under the 1986 amendments and does not explain the particular changes accomplished by the 1988 amendments, I would not entirely reject the import of this expressed congressional understanding, as does the majority opinion, because that commentary implicates a budgetary concern of some magnitude which had to be taken into account in adopting the 1988 amendments. I agree with the majority, however, that such legislative history must be reviewed cautiously.

As a consequence, Congress repealed 42 U.S.C. § 1396a(a)(15) which had been applicable only to dual-eligibles.

It would be misleading to conclude from the new singular definition of "qualified medicare beneficiary," however, that Congress intended the coinsurance payment obligation of the states to be identical for dual-eligibles and pure QMBs. In fact, in the 1988 amendments Congress explicitly added language to the exceptions clause attached to § 1396a(a)(10)(E) indicating that § 1396a(n) continued to apply solely to pure QMBs, as it did in 1986. The combination of the congressional repeal of the needs-based test for dual-eligibles in old § 1396a(a)(15) and the restriction of the "may provide" language in § 1396a(n) to apply only to pure QMBs is sufficient evidence that Congress intended to require full reimbursement for dual-eligibles – but for them only.

Thus, the history of the 1986 and 1988 amendments leads to the following conclusions. The statutory scheme prior to the 1988 amendments required coinsurance payments for dual-eligibles to the extent that the beneficiary could not pay, according to some "reasonable" scale of need as determined by the state. 42 U.S.C. § 1396a(a)(15) (repealed in 1988). If my reading of the 1986 amendments is correct, they did not require *any* such payments for pure QMBs. Thus, the 1988 amendments effectively changed the states' payments obligation for only one of the two groups. The payment obligation for pure QMBs

remained flexible,[10] while the payment obligation for dual-eligibles went from a needs-based standard to a requirement of 100 percent reimbursement.

IV

I remain with the firm belief that mine is the most accurate interpretation of the statutes. Notwithstanding that conviction, I am also prepared to acknowledge that the statutory language may not give rise to a single conclusive interpretation and that one cannot derive a definitive interpretation from the nature of the multitudinous amendments made over the years. While the proper limit of our judicial function is coterminous with our power to interpret, I am willing to concede there are circumstances that fall beyond the limits of reason. In this instance, therefore, I am not prepared to order a construction in conflict with the view of the agency happily charged with these statutes' interpretation. Accordingly I conclude it best, in light of all the circumstances, that we defer to the agency.

Congress has given the Secretary the power to administer both the Medicare and Medicaid Acts, *see* 42 U.S.C. §§ 1395ff(a), 1396a(b), and deference is due to the Secretary's interpretations of them under the principles announced in *Chevron U.S.A. v. Natural Resource Defense Council*, 467 U.S. 837 (1984). Those principles, which are

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[10] Subject to the caveat that any cost sharing charged imposed could only be "nominal in amount." *See* 42 U.S.C. § 1396*o*(a)(3).

well known but merit repeating here, are stated quite simply:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.
>
> * * *
>
> If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute. Sometimes the legislative delegation to an agency on a particular question is implicit rather than explicit. *In such a case, a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency.*

Id. at 842-44 (emphasis added) (footnotes omitted). *See also, Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 702

(1991) ("[I]t is axiomatic that the Secretary's interpretation need not be the best or most natural one by grammatical or other standards. . . . Rather, the Secretary's view need be only reasonable to warrant deference.").

The deference mandated by *Chevron* has a number of justifications. It insures that agencies – which are more politically accountable than federal courts – have final say on matters of policy not resolved by Congress.

> While agencies are not directly accountable to the people, the Chief Executive is, and it is entirely appropriate for this political branch of the Government to make such policy choices – resolving the competing interests which Congress itself either inadvertently did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities.

Chevron, 467 U.S. at 865-66. In addition, the judicial deference to agency interpretations mandated by *Chevron* "increases the prospect of uniform federal regulatory law and reduces the burden on the Supreme Court of insuring that uniformity." Laurence A. Silberman, *Chevron – The Intersection of Law & Policy*, 58 Geo. Wash. L. Rev. 821, 824 (1990). Finally, Congress may be better equipped to draft legislation with knowledge of how an agency, with a track record of interpretation and hard-earned expertise in the field, is likely to read its language. *See* Antonin Scalia, *Judicial Deference to Administrative Interpretations of Law*, 1989 Duke L. J. 511, 517 (1989). Thus, where we are not convinced that Congress has spoken to a matter, we should grant discretion to an agency because of its special competence to fill the statutory gap.

Where an agency is given discretion to administer a "complex and highly technical regulatory program," it is entitled to an even greater degree of deference from the courts. *BethEnergy Mines*, 501 U.S. at 697. The provisions of the Medicaid and Medicare Acts at issue here are just the sort of complicated statutes that are entitled to this special deference. *See Mowbray v. Kozlowski*, 914 F.2d 593, 598 (4th Cir. 1990) ("Judicial deference is especially appropriate in the area of welfare administration."). I believe that the courts must acknowledge their lack of expertise in such complicated fields and, in the face of an unresolvable ambiguity, accord extra deference to the appropriate agency which has the greater familiarity with the statutory scheme at issue.

In this case, I would also grant extra deference to the position of the Secretary because of the major financial ramifications of our decision. Affidavits submitted by the Director of the Virginia Department of Medical Assistance Services state that the reading urged by the Rehabilitation Association would cost an additional $10 million annually. Assuming that federal matching funds are available for half of that total, Virginia would be forced to budget an extra $5 million annually just to cover the costs inherent in the Rehabilitation Association's interpretation, at a time when Virginia already projects significant budget shortfalls. According to representations from counsel at oral argument, almost half of the states in the country have similar limitations upon coinsurance payments, so that a ruling that full payment is mandatory could have an even greater fiscal impact. With so great a budgetary change at stake, I am convinced that we should be especially sure of the result Congress

intended before acting, and failing that confidence, we should defer to the federal and state agencies which regularly and continuously operate under the statutes' terms.

In short, while I continue to believe that my statutory interpretation is more persuasive than that urged by the majority, the fact that the majority opinion and my opinion – both of which are purportedly grounded on a rational interpretation of the statutes – arrive at significantly different results surely manifests an actual ambiguity and an almost self-evident lack of clarity in the statutes. In these circumstances, I believe that the court has no other alternative but to defer to the agency charged with interpretation and enforcement of the statutes, particularly in light of the major budgetary implications. Accordingly, I would reverse the judgment of the district court, and therefore I respectfully dissent.

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
February 23, 1995

No. 93-2572

CA-93-402-R

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED

Plaintiff-Appellee

v.

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia

Defendant-Appellant

and

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

Defendant

On Petition for Rehearing with
Suggestion for Rehearing In Banc

The appellant's petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Bert M. Montague
CLERK

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
March 23, 1995

No. 93-2572

CA-93-402-R

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED

Plaintiff-Appellee

v.

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia

Defendant-Appellant

and

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

Defendant

No. 94-1134

CA-93-402-R

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED

Plaintiff-Appellee

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

Defendant-Appellant

and

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia

Defendant

ORDER

The Commonwealth has filed a motion to recall and stay the mandate.

The Court grants the Commonwealth's motion to recall the mandate and to stay the mandate for thirty days pursuant to Federal Rules of Appellate Procedure 41(b).

Entered at the direction of Judge Ervin, with the concurrence of Judge Niemeyer and Judge Williams.

For the Court,

/s/ Bert M. Montague
CLERK

FILED: April 14, 1995

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 93-2572
(CA-93-402-R)

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED,

Plaintiff-Appellee,

versus

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia,

Defendant-Appellant,

and

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

No. 94-1134
(CA-93-402-R)

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED,

Plaintiff-Appellee,

versus

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellant,

and

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia,

Defendant.

ORDER

The Commonwealth has filed a supplemental motion to recall mandate and extend stay in case Nos. 93-2572 and 94-1134. Appellee has filed a letter response to the motion to recall mandate and extend stay. The government has filed a letter response to the motion.

The Court grants the supplemental motion to recall and extend the stay in these cases until the United States Supreme Court acts on the Commonwealth's petition for writ of certiorari.

Entered at the direction of Chief Judge Ervin with the concurrence of Judge Niemeyer and Judge Williams.

For the Court

/s/ Bert M. Montague
Clerk

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

REHABILITATION ASSOCIATION OF VIRGINIA, INC., Plaintiff, v. BRUCE U. KOZLOWSKI, as Director of Virginia Department of Medical Assistance Services, and DONNA E. SHALALA, as Secretary of the United States Department of Health and Human Services, Defendants.	Case No. 3:93CV402 (Filed Nov. 22, 1993)

ORDER

The Court is in receipt of Plaintiff's motion for summary judgment pursuant to Federal Rule of Civil Procedure 56 and Defendants' motions to dismiss or for summary judgment under Federal Rules 12(b) and 56. For the reasons stated in the accompanying Memorandum, and deeming it just and proper so to do, it is hereby ADJUDGED and ORDERED that Plaintiff's motion be and the same is hereby GRANTED. Furthermore, upon due consideration, and deeming it just and proper so to do, it is hereby ADJUDGED and ORDERED that Defendants' motions be and the same are hereby DENIED.

It is accordingly ADJUDGED, DECLARED, AND ORDERED as follows: State Plan Amendments 88-08, 90-16, and the Subsequent Amendments, as applied so as

to eliminate direct payment by the Commonwealth of Medicare cost-sharing amounts to rehabilitation agencies for outpatient therapy services furnished to all QMBs, and Amendment 90-29, to the extent that it reduces or eliminates payment by the Commonwealth of the full Medicare cost-sharing amounts for Part B covered services furnished to all QMBs, are unlawful, unconstitutional, and invalid, and the Commonwealth's implementation thereof is unlawful, unconstitutional, and invalid. The Secretary's actions with respect to State Plan Amendments 88-08, 90-16, and the subsequent Amendments, as applied so as to eliminate direct payment by the Commonwealth of Medicare cost-sharing amounts to rehabilitation agencies for outpatient therapy services furnished to all QMBs, and Amendment 90-29, to the extent that it reduces or eliminates payment by the Commonwealth of the full Medicare cost-sharing amounts for Part B covered services furnished to all QMBs, are arbitrary, capricious, an abuse of discretion, and otherwise not in accordance with law, and accordingly are invalid.

It is further ADJUDGED and ORDERED that the Commonwealth Defendant, Bruce U. Kozlowski, his successors, agents, officers, servants, employees and all working in concert therewith be and he and they are hereby permanently enjoined from implementing or attempting to implement State Plan Amendments 88-08, 90-16, the Subsequent Amendments, and 90-29 to the extent that they are applied so as to eliminate direct and full payment by the Commonwealth of Medicare cost-sharing amounts to rehabilitation agencies for therapy services furnished to all QMBs.

It is further ADJUDGED and ORDERED that the individuals in the immediate preceding paragraph make direct and full payment of Medicare cost-sharing amounts to rehabilitation agencies for therapy services furnished to all QMBs.

Plaintiff shall recover their taxable costs and shall also recover reasonable counsel fees and expenses. The parties are directed to meet and confer in an effort to reach an amicable adjustment of said fees and expenses.

In the event the parties cannot agree, Plaintiff shall within 30 days file appropriate documents under oath specifying what they claim to be entitled to by way of said fees and costs. Defendant is granted fifteen (15) days after receipt of Plaintiff's filings to respond thereto.

Let the Clerk of Court send a copy of this Order and the accompanying Memorandum to all counsel of record.

/s/ Robert R. Merhige, Jr.
UNITED STATES DISTRICT
JUDGE

NOV 22 1993 Date

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

REHABILITATION ASSOCIATION OF VIRGINIA, INC., Plaintiff, v. BRUCE U. KOZLOWSKI, as Director of Virginia Department of Medical Assistance Services, and DONNA E. SHALALA, as Secretary of the United States Department of Health and Human Services, Defendants.	Case No. 3:93CV402 (Filed Nov. 22, 1993)

MEMORANDUM

This matter came before the Court on October 18, 1993 on cross motions for summary judgment pursuant to Federal Rule 56, and defendants' motion to dismiss under Federal Rule 12(b). Plaintiff Rehabilitation Association of Virginia ("the Association")[1] brought this action against Bruce U. Kozlowski, Director of the Virginia Department of Medical Assistance Services, ("the Director") and Donna E. Shalala, Secretary of the United States Department of Health and Human Services, ("the Secretary")

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[1] Plaintiff Rehabilitation Association of Virginia, Inc. is an association of rehabilitation agencies with its principal place of business in Glen Allen, Virginia. At all times relevant to this action, members of the plaintiff Association provided health care services to dual eligibles and other QMBs.

challenging certain statutes pertaining to the Commonwealth's Medicaid State Plan as violative of the federal Medicare and Medicaid Acts.[2] The parties agreed to dispense with the non-jury trial scheduled for November 5, 1993 and submit the matter for final disposition on the instant motions.

Background

In 1988, the Virginia General Assembly adopted legislation and a State Medicaid Plan amendment which altered the billing procedures for Medicaid services to Medicaid patients. These enactments, and their legality under the Federal Medicare and Medicaid Acts, are the basis for the instant action. Plaintiff contends that Virginia Plan Amendment 88-08[3] unlawfully prohibits

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[2] 42 U.S.C. §§ 1395 *et seq* ("the Medicare Act"), 42 U.S.C. §§ 1396 *et seq* ("the Medicaid Act").

[3] Plan Amendment 88-08 provides:

> The State Board of Medical Assistance Services shall develop amendments to the State Plan for Medical Assistance and seek the Health Care Financing Administrations's approval to provide that: . . . [in paragraph 5.] Effective on and after July 1, 1988, reimbursement will not be made directly to physical therapy providers for physical therapy services provided to Medicaid patients residing in long term care facilities that are subject to prospective reimbursement. Reimbursement for these services is and will continue to be included within the allowable operating cost ceilings as established under Virginia's prospective payment system. Prospective operating rates for such long term care facilities that have not previously included such costs in their cost reports shall not be

therapy providers from submitting separate claims for Medicaid payment and illegally provides that the costs of physical therapy services be included in the calculation of the nursing facility's Medicaid per diem rate. Also, plaintiff argues that Virginia Plan Amendment No. 90-29, approved by the Secretary effective January 1, 1991, unlawfully limits the Commonwealth's "cost-sharing" in Medicare "Part B" services for "Qualified Medicare Beneficiaries" ("QMBs") to the reimbursement level established by Medicaid. Plaintiff maintains that Virginia is legally obligated to pay the entire difference for services to QMBs rather than the often lesser amount established by Medicaid. Before addressing in detail the effect of these enactments, and their viability under statutory authority, a brief discussion of the Medicare/Medicaid scheme is appropriate.

The Medicare Act is generally divided into two parts. Under "Part A," the federal government provides people who are 65 years of age and older and certain disabled individuals with an inpatient hospital insurance plan. 42

> adjusted for physical therapy service costs until actual allowable costs incurred for these services are reflected in cost reports for fiscal years beginning subsequent to July 1, 1988. Costs incurred as a result of this change will not be considered justification for approving a change to any providers cost reporting period . . .

The "direct billing" prohibition was extended by Plan Amendment No. 90-16 to cover occupational therapy and speech therapy services.

U.S.C. §§ 1395c-1395i-4. In addition, "Part B" of the Medicare Act provides that people who are eligible for Medicare may voluntarily obtain supplementary insurance for other medical care, including hospital outpatient services and other services that are generally not covered under Part A. Part B of the Medicare statute is involved in this action.

In order to be covered by Part B, a Medicare-eligible person must pay insurance premiums. Further, Part B obligates the federal government to pay 80% of the "reasonable costs" of outpatient hospital services and 80% of "reasonable charges" for physician services rendered to the insured. The remaining 20% of the reasonable costs and charges, the "coinsurance" amount, and the annual deductible are paid by the Medicare patients themselves.

The Medicaid Act, as opposed to the Medicare Act, provides for a joint federal and state funded system which subsidizes medical care for the needy, regardless of age. States participating in Medicaid must propose a plan which must be approved by the Secretary as conforming with federal requirements. 42 U.S.C. §§ 1396a(a) and 1396a(b). The state plan must include a schedule of payment rates which the state designates or the services that a Medicaid patient might seek. Once the Secretary approves a state's plan, the federal government will assist the state in its reimbursement program with Federal Medicaid funds. The health care providers who treat Medicaid patients must agree to accept the Medicaid rate and not ask the patient to pay any money beyond that point.

An additional component of the Medicare Act, and one significant to the instant action, is the QMB provision. The authors of the Medicare Act recognized that the cost of enrolling in the optional Part B program (the 20% coinsurance and the annual deductible) might prohibit certain poor Medicare-eligibles (those who are eligible for Medicaid as well) from receiving Part B services. Accordingly, the Act provided for states to enroll the poorest of the Medicare beneficiaries, i.e. those "dually eligible" for Medicaid, in the Part B program by entering into a "buy-in" agreement with the Secretary and paying the premiums on their behalf. In addition, the state Medicaid programs were to pay Medicare deductibles and coinsurance amounts to the extent that the individual could not.

In 1989, Congress expanded this protection for the elderly poor and provided that state Medicaid programs were required to pay Medicare cost-sharing on behalf of QMBs. Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), Pub. L. No. 99-509, § 9403, 100 Stat. 2045 (1986). QMBs were defined to include all medicare-eligible individuals with incomes below federal poverty levels. Thus, "QMB" includes those who are "dually eligible" as well as other poor Medicare beneficiaries. 42 U.S.C. § 1396a(a)(10)(E). In this case, Plaintiff challenges both the *mechanics* of payments made by the state for services rendered to QMBs as well as the *rate* at which the state reimburses therapy providers for their services to QMBs.

When therapy services are rendered to a Medicare patient who is also eligible for Medicaid, the Medicare program pays the therapy provider 80% of the reasonable

cost for these services. The Commonwealth, plaintiff argues, is liable for the entire 20% coinsurance when such services are provided to a QMB. However, plaintiff argues, pursuant to Plan Amendment 88-08, the Commonwealth no longer pays the 20% Part B coinsurance for therapy services furnished to QMBs in nursing facilities. Plaintiff has no quarrel with the direct billing amendments to the extent they prohibit the submission of separate Medicaid claims furnished to Medicaid patients who are not also Medicare-eligible (so-called "pure" Medicaid patients). What plaintiff challenges in this action is the application of the direct billing amendments so as allegedly to eliminate payment of Medicare Part B cost-sharing to rehabilitation agencies for therapy services furnished to Medicare patients: the dual eligibles and other QMBs. Under the Medicare Act, plaintiff contends, the Commonwealth must pay the deductible and 20% Medicare coinsurance to the provider for all QMBs.

Plaintiff also challenges Virginia Plan Amendment 90-29 which provides for payment by the Commonwealth of Medicare Part B cost-sharing for QMBs only to the extent that the amount paid by the Commonwealth, plus the 80% Medicare payment, does not exceed the level of reimbursement established for such service by the Medicaid program. In short, plaintiff complains that when the Medicaid rate for a service is lower than the Medicare-approved reasonable cost or charge, the Commonwealth will limit payment of the Medicare cost-sharing so that the total payment to the provider does not exceed the Medicaid rate. Further, plaintiff states that if the

Medicaid rate is lower than the 80% Medicare payment, the Commonwealth pays no cost-sharing.[4]

This memorandum will first address the threshold arguments regarding standing, failure to state a claim, and statute of limitations raised by defendants in their respective motions. Next, the Court will discuss the legality of the direct billing prohibition and the Medicaid rate limitation under the Medicare and Medicaid Acts.

Discussion

The Director first asserts that the Association lacks standing to bring this action. The Director argues that, under *Warth v. Seldin*, 422 U.S. 490 (1975) and *Hunt v. Washington State Apples Advert. Comm'r*, 432 U.S. 333 (1977), in order to have standing an association must show that its members would otherwise have standing to sue in their own right, that the interests the association seeks to protect are germane to the organization's purpose, and that neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. *Hunt*, 432 U.S. at 343.

The Association, defendants argue, has failed to satisfy each of the requirements for associational standing. Defendants maintain that there is no allegation in this

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[4] Plaintiff offers the following example: If the Medicare-approved reasonable cost or charge is $100, Medicare will pay $80 (80% of $100). If the Medicaid rate for that service is $90, the Commonwealth will pay only $10 of the $20 Medicare coinsurance amount. If the Medicaid rate is lower than $80, the Commonwealth will pay no Medicare coinsurance.

case that any rehabilitation agency has made a claim for payment, either to a nursing facility, a third-party payer, or to the Medicaid program. As such, defendant avers, there has been no injury. The Director adds that, in order to determine whether the Association members were paid properly, it would be necessary to examine each and every contract between a rehabilitation agency and a nursing facility. Relying on *Kansas Health Care Ass'n v. Kansas Dep't of Social & Rehab. Servs.*, 958 F.2d 1018 (10th Cir. 1992), the Director contends that this case requires the participation of individual entities not before the Court.

Plaintiff submits that the Director mischaracterizes the Association's claim. Plaintiff asserts that its claim is that the Commonwealth is required by statute to pay Medicare cost-sharing to rehabilitation agencies, not that nursing facilities are so required pursuant to statute or otherwise. The mere fact that the state has announced its policy not to pay rehabilitation agencies the cost-sharing amounts creates sufficient injury, regardless of whether individual agencies have submitted claims contrary to that policy. Plaintiff, citing *National Ass'n of Rehabilitation Facilities, Inc. v. Schweiker*, 550 F. Supp. 357 (D.D.C. 1982), argues that its organizational purposes clearly confer standing to bring the instant suit. Plaintiff adds that no individualized proof is required to determine whether federal law requires states to pay Medicare cost-sharing.

On the issue of standing, the Court finds that plaintiff has satisfied the requirements set out in *Warth* and *Hunt*. In *Hunt*, the Court commented, "If the Commission were a voluntary membership organization – a typical trade association – its standing to bring this action as the

representative of its constituents would be clear under prior decisions of this Court." *Hunt*, 432 U.S. at 342. The Court cited *Warth*, stating "Even in the absence of injury to itself, an association may have standing solely as the representative of its members . . . " *Id.* at 511. The Court is satisfied that plaintiff's claim that the Commonwealth's amendments to its State Plan violate federal law brings this action within the standing requirements articulated in *Hunt*. *See National Ass'n of Rehabilitation, Etc. v. Schweiker*, 550 F. Supp. 357, 365 (D.D.C. 1982).

The Director also asserts that plaintiff has failed to state a claim upon which relief can be granted. The Director argues that 42 U.S.C § 1983,[5] under which the Association brings this claim, cannot apply in this case because neither the Medicare Act nor the Medicaid Act creates any enforceable right regarding direct billing or the Medicaid rate limitation. Defendant cites *Cort v. Ash*, 422 U.S. 66 (1975) for the three factors relevant to a § 1983 claim.

> First, is the plaintiff one of the class for whose *especial* benefit the statute was enacted, . . . that is does the statute create a federal right in favor

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[5] Section 1983 provides, in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proceeding for redress.

42 U.S.C. § 1983.

> of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? . . . Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?

Id. at 78 (citations omitted). The Director argues that plaintiff cannot satisfy any of the requirements to state a claim under § 1983.

Plaintiff contends that the right it seeks to enforce, the statutory right to state payment of Medicare cost-sharing, is enforceable under § 1983. Plaintiff argues that the factors in *Cort* relate to the question of whether a private right of action can be implied from a statute, not whether a statute creates an enforceable right under § 1983. According to plaintiff, the operative inquiry is whether "the provision in question was intend[ed] to benefit the putative plaintiff." *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 508 (1990). If the statute reflects a binding obligation on the governmental unit as opposed to merely a "congressional preference" for a certain kind of conduct, then the statute creates an enforceable right under § 1983. In addition, the interest asserted cannot be "too vague and amorphous" such that it is "beyond the competency of the judiciary to enforce." *Id.* Under *Wilder*, plaintiff submits, § 1983 is a proper vehicle for enforcing the statutory provisions requiring states to pay Medicare cost-sharing for QMBs.

The Court has concluded that plaintiff has stated a claim for which relief can be granted under § 1983. The QMB cost-sharing provision, § 1396a(a)(10)(E) creates a right that is "sufficiently specific and definite to qualify

as [an] enforceable righ[t] under *Pennhurst* and § 1983 [and was] not . . . beyond the competence of the judiciary to enforce." *Wilder*, 496 U.S. at 512, quoting *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 432 (1987). Whereas providers in *Wilder* had enforceable rights under § 1983 to challenge the adequacy of Medicaid rates under § 1396a(a)(13)(A), so too do providers have enforceable rights to challenge a state's obligations under the cost-sharing provisions in § (a)(10)(E).

The Director contends that, to the extent the Association states a § 1983 claim, it is time barred. Relying on *United Steelworkers v. Dalton*, 544 F. Supp. 291, 296 (E.D. Va. 1982), defendant argues that suits brought pursuant to § 1983 are governed by the statute of limitations borrowed from state law. As such, the Director submits, the Virginia two-year statute of limitations for personal actions governs § 1983 claims. Va. Code Ann. § 8.01-243 (1992 Repl. Vol.). Federal law, defendant argues, governs the time of accrual and establishes that time at the point when the plaintiff knew, or had reason to know, of the injury which forms the basis of the action. *See Bireline v. Seagondollar*, 567 F.2d 260 (4th Cir. 1977). The Association's claims based on the direct billing amendments and the Medicaid rate limitation amendment both were brought more than two years after the respective enactments. Therefore, defendant contends, the claims based thereon must be dismissed for failure to timely file.

Plaintiff argues that its claims are not time barred due to the continuing nature of the challenged actions. Since the state continues to apply the payment limitations, and since the Secretary's approval persists, the

violations, plaintiff correctly asserts, can only be considered continuing. Plaintiff cites *National Advertising Co. v. City of Raleigh*, 947 F.2d 1158 (4th Cir. 1991) stating, "With respect to statutory or regulatory challenges, we have previously found a continuing violation where regulations continued to be applied to persons within the statutory limitations period." *Id.* at 1167, citing *Virginia Hospital Ass'n v. Baliles*, 868 F.2d 653, 663 (4th Cir. 1989), *aff'd sub nom. Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990).

On the basis of *National Advertising* and *Baliles*, the Court finds that plaintiff's claims are not time barred. In *Baliles*, the plaintiff's challenge to Virginia's procedures for reimbursing hospitals for the cost of treating Medicaid patients was brought four years after the adoption of the procedures. The court concluded that the claim "was not barred by Virginia's applicable two-year statute of limitations." *Id.* at 1167. Rather than focusing on defendant's initial actions, plaintiff in this case, like plaintiff in *Baliles*, challenges the continuing application of an allegedly unlawful policy. Due to the continuing nature of the alleged harm, the Court will deny defendants' motions on the statute of limitations bar.

The Director's final threshold challenge alleges that the Association's claim is barred by the Eleventh Amendment to the United States Constitution.[6] Despite the

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[6] The Eleventh Amendment states:
The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state.
U.S. Const. amend. XI.

exception to Eleventh Amendment immunity for suits that charge state officials with violations of federal law and request prospective relief, as recognized in *Ex Parte Young*, 209 U.S. 123 (1908), defendant asserts that this action is nonetheless constitutionally barred. Citing *Edelman v. Jordan*, 415 U.S. 651, 663 (1974), defendant argues that when a claim is in essence one for recovery of money from the state, and individual officials are nominal defendants, the action is barred by the Eleventh Amendment. Plaintiff's claim, defendant argues, is precisely the type of claim barred on Eleventh Amendment grounds by *Edelman*.

Plaintiff, on the other hand, points to the fact that it does not seek retroactive money damages barred by the Eleventh Amendment, but rather prospective injunctive relief and a declaratory judgment. Under *Edelman*, plaintiff asserts, a federal court may grant prospective injunctive relief against unlawful state action even where the necessary effect of such relief would result in future substantial payments of such state funds.

Defendant's reliance on *Edelman* in support of an alleged Eleventh Amendment bar is, in this instance, misplaced. The *Edelman* Court held that "a federal court's remedial power, consistent with the Eleventh Amendment, is necessarily limited to prospective injunctive relief . . . and may not include a retroactive award which requires the payment of funds from the state." *Id.* at 677. The relief plaintiff seeks, therefore, is permissible under the Eleventh Amendment.

In its substantive claims plaintiff asserts that the Commonwealth's actions, and the Secretary's approval,

regarding the prohibition on direct billing and the Medicaid rate limitation violate both the Medicare Act and the Medicaid Act. Plaintiff argues that the Medicare Act requires that providers of Medicare Part B services be paid their full reasonable costs and charges by means of the combined Medicare 80% payment and the cost-sharing amounts. Plaintiff maintains that this requirement applies fully in the case of all QMBs, and the Commonwealth's payment of cost-sharing only up to the Medicaid rate as well as its refusal to make payments directly to providers of therapy services furnished to QMBs violate the Medicare Act. Similarly, plaintiff contends, the Medicaid Act requires payment of Medicare Part B cost-sharing in full, and that such payments be made directly to providers of therapy services furnished to QMBs.

Unquestionably, is a fundamental precept of the Medicare Act that providers are entitled to recover their reasonable costs or charges for providing services, including Part B services, to all individuals eligible for Medicare benefits. The Medicare program, plaintiff contends, must pay 80% of the Medicare-approved amount and providers may charge Medicare beneficiaries or other persons the cost-sharing amounts. In support of its claim for full reimbursement, plaintiff points to the fact that the Medicare Act expressly provides:

> A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to . . . section 1395*l*(b) . . . and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services . . . for which payment is made under Part B . . .

42 U.S.C. § 1395cc(a)(2)(A). Further, plaintiff cites *New York City Health and Hospitals Corp. v. Perales*, 954 F.2d 854, 858 (2d Cir. 1992) for the proposition that "there is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers express statutory right to recover their full reasonable costs or charges." *Id.* In *Perales*, the Court of Appeals for the Second Circuit invalidated a New York Regulation and Plan Amendment that limited the state's cost-sharing contribution to the Medicaid rate for dual eligibles and other QMBs. The federal government in *Perales* took the position that dual eligibles and other QMBs were "primarily Medicaid patients" to whom the Medicare Act provisions entitling providers to reasonable costs and charges do not apply.

Plaintiff notes that the Medicaid rate limitation in Virginia Plan Amendment 90-29 is virtually identical to the New York Plan Amendment invalidated in *Perales*. Moreover, plaintiff asserts that the Secretary has acknowledged that at least "pure QMBs," i.e. those not dually eligible, cannot be deemed Medicaid patients for purposes of the direct billing limitations.[7] Any distinction

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[7] In a letter to one of plaintiff's members dated July 16, 1992, the Secretary stated:

> Some Medicare beneficiaries who meet certain income and resource tests may qualify for Medicaid as qualified Medicare beneficiaries (QMBs). Each state sets its own guidelines for who qualifies for this assistance. Under this program, state governments assist qualified Medicare beneficiaries by paying the monthly Medicare premiums. If a nursing home resident is eligible as a QMB only, and is not also eligible for payment for Medicaid State plan services, it is

the Secretary may draw between "pure QMBs" and dual eligibles, plaintiff asserts, cannot be reconciled with the Medicare Act or *Perales*.

With respect to the legality under the Medicare Act of the direct billing prohibition, *Perales* establishes that all state limitations on providers' rights to recover their reasonable costs and charges for furnishing services to Medicare-eligible patients, including dual eligibles and other QMBs, are unlawful. Plaintiff points to Medicare Regulation 42 C.F.R § 410.150(a)(1), which provides that "any [Part B] enrollee is . . . entitled to have payment made" under Part B "to a . . . rehabilitation agency on the individual's behalf for outpatient physical therapy or speech pathology services furnished by the . . . agency . . . " *Id.* at § 410.150(b)(7). Under *Perales*, plaintiff argues, all Medicare beneficiaries must be treated uniformly, and no one group may be considered "primarily Medicaid."

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immaterial whether the State plan considers the Medicare Part B service as part of the per diem under Medicaid. States are required to pay for the Medicare Part A and Part B deductibles and coinsurance for all Medicare services whether or not the services are covered under the Medicaid State plan. This means that if Medicare considers physical therapy separately for payment, the state must also consider the physical therapy separately for Medicare coinsurance purposes for QMBs.

With respect to dually eligible QMBs, the Secretary stated:

> Unlike the Medicare program, a state has the latitude to require that therapy services be considered an inpatient benefit and included in the payments made to the NF [nursing facility].

Further, the Court is of the view that the Amendments violate the Medicaid Act provisions applicable to QMBs. The Medicaid Act requires that a state plan provide "For making medical assistance available for medicare cost-sharing . . . for qualified medicare beneficiaries." Under § 1396d(p)(1) QMBs are defined to include all individuals entitled to Part A benefits with incomes below certain federal poverty levels. Plaintiff notes as well that "cost-sharing" is defined as including all Medicare cost-sharing amounts. These amounts include premiums, coinsurance, deductibles, and

> the difference between the amount that is paid under section 1395*l*(a) [*i.e.* 80% of the reasonable costs and charges for covered Part B services] and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent.'

§ 1396d(p)(3). Plaintiff contends that the Commonwealth's practice of paying Medicare cost-sharing for Part B services to QMBs only to the extent the cost-sharing, plus the 80% Medicare payment, do not exceed the Medicaid rate conflicts with the plain language of § 1396a(10)(E).[8] In invalidating the New York Medicaid rate limitation, the *Perales* court stated, "It is counterintuitive that a statute requiring Medicaid funds to be made available for [Medicare] cost-sharing only to the

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[8] 42 U.S.C. § 1396a(a)(10)(E) requires that "[a] State plan for medical assistance [Medicaid] must . . . provide . . .

> for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(l) . . . "

extent of the Medicaid scheduled rates would not specify that qualification expressly." *Id.* at 859. Accordingly, plaintiff asserts, the Commonwealth cannot limit its cost-sharing obligation by paying the difference between 80% and the Medicaid rate.

Finally, plaintiff maintains that, not only is it not factually correct to conclude that the Commonwealth includes the coinsurance amounts in the Medicaid per diem payments to nursing facilities, it is unlawful under the Medicaid Act to make Part B cost-sharing payments in any way other than directly to the therapy providers. Plaintiff argues that the Secretary's distinction between "pure" QMBs and dual eligibles for purposes of direct billing simply exposes the fact that states are required to pay Medicare cost-sharing directly to providers of Part B services. When Congress eliminated the distinction between dual eligibles and other QMBs in OBRA 1986, plaintiff contends, it required payment in full for all QMBs. Additional amendments in 1989, P.L. 100-360, § 301(a)(1), 102 Stat. 683, 748, further support the Commonwealth's obligation to make direct payments to providers furnishing Part B services to all QMBs. The Commonwealth cannot, plaintiff asserts, discharge its statutory duty to make direct payments to therapy providers by making payments to the nursing facility, an entity under no legal obligation to remit payment to the provider of service.

Both the Secretary and the Director contend that nothing in either the Medicare Act or the Medicaid Act speaks to the issue of to whom payment of Medicare Part B coinsurance and deductibles must be made. Plaintiff's members, defendants assert, have no statutory right to

direct payment. The direct billing prohibition, the Director argues, is the lawful outgrowth of steps taken by the Commonwealth to avoid double billing abuses in the past by therapy providers. By shifting the payment scheme from direct payment to payment of the therapy providers through the nursing facility's per diem rate, the Director explains, the Commonwealth avoided paying for medically unnecessary services, as required by § 1396a(a)(30)(A).

The Secretary and the Director both submit that, there being no specific language in either Act requiring direct payment to therapy providers for Part B services rendered to QMBs, the gravamen of plaintiff's complaint concerns the business arrangements the rehabilitation facilities have made with nursing facility providers. The rehabilitation facilities are free, defendants contend, to contract with nursing facilities and be paid the equivalent of Medicaid cost sharing. Perhaps more importantly, the Director asserts, no entity, including rehabilitation services providers, has a right to be a Medicaid provider, citing *Oberlander v. Perales*, 740 F.2d 116 (2d Cir. 1984). Defendants contend that whether rehabilitation agencies chose to provide services to nursing facilities under contracts that waive any entitlement to amounts equal to Medicare cost-sharing is a matter of private contract and does not implicate a federal question at all.

Further, the Director contends that the prospective payment rate established for nursing facilities clearly results in payment by Medicaid to the rehabilitation agency for Part B services. Defendants rely on *Haynes Ambulance Service, Inc. v. Alabama*, 820 F. Supp. 590 (M.D. Ala. 1993), in which the court stated:

> Nothing in the Medicaid or Medicare statutes furnishes any evidence that Congress ever focused on what percentage of "reasonable" Part B provider costs should be borne by the states for QMBs. Although Congress expressly mandated that the State pay full reasonable costs for Part A . . . nowhere in the statute or accompanying legislation is there language decreeing that the states pick up the tab for those obtaining Part B outpatient services.

Id. at 593.

The Secretary argues that plaintiff's reading of the July 16, 1992 letter regarding payment of cost-sharing amounts directly to the provider for "pure" QMBs as opposed to dual eligibles is erroneous. Since "pure" QMBs are non-Medicaid-eligible individuals, the Secretary explains that the per diem rates do not apply to them. Moreover, the Secretary asserts that nothing in the letter suggests that it is her position that § 1396a(a)(10)(E) requires a certain payment procedure for "pure" QMBs or any other QMBs. The Secretary also contends that plaintiff has no right of action against her under the Supremacy Clause and the Fourteenth Amendment, that the Medicaid Act does not provide a private right of action, *Michigan Hospital Ass'n v. Department of Social Servs.*, 738 F. Supp. 1080 (W.D. Mich. 1990), and that the Medicare Act precludes judicial review except under 42 U.S.C. § 405(g). 42 U.S.C. § 1395ff(b). The Secretary also urges that plaintiff's claims are not reviewable under the Administrative Procedure Act. 5 U.S.C. § 704.

Regarding plaintiff's argument that the Commonwealth is prohibited from reimbursing providers under

the Medicaid rate, both defendants contend that §§ 1396a(a) and 1396a(n) specifically permit the reimbursement scheme of which plaintiff complains. Section 1396a(a) provides:

> [T]he medical assistance made available to a qualified medicare beneficiary . . . shall be limited to medical assistance for medicare cost-sharing . . . subject to the provisions of subsection (n) and section 1916(b) . . .

Section 1396a(n) provides:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

§ 1396a(n). Defendants argue that these two provisions read together reveal that cost-sharing amounts may or may not be paid by the Commonwealth where the total cost of the Medicare services exceeds the total amount that Medicaid would otherwise pay for such services for any other Medicaid-eligible individual. Through 1396a(n), defendants urge, Congress merely sought to assure those states choosing to pay above Medicaid rates that they would receive federal matching dollars. Defendants point to the language "the State plan may provide . . . " in 1396a(n) to support their argument that

Congress took a permissive approach in setting cost-sharing rates for services under Part B to QMBs.

The conflicting interpretations of the Medicare and Medicaid Acts as they relate to the Medicaid rate limitation within the Virginia State Plan specifically addressed in the opposite conclusions reached by the courts in *Perales* and *Haynes*. On the one hand, the court in *Perales* first determined that there is an express statutory right on the part of providers to receive their full reasonable costs or charges. *See Mercy Community Hosp. v. Heckler*, 781 F.2d 1552, 1556-57 (11th Cir. 1986) ("Congress has stated that Medicare providers shall be reimbursed for the reasonable costs, both direct and indirect, they incur in rendering health care services to Medicare beneficiaries"). Based on that premise, the court concluded that the New York Regulation that precluded providers who served dual eligibles and QMBs from collecting more than 80% of their reasonable costs or charges violated the Medicare Act. The *Perales* court was not persuaded that the apparently permissive language of § 1396a(a) allowed cost-sharing only up to the Medicaid rate.

In *Haynes*, however, the court found that the provisions in the Alabama State Plan permitting providers treating QMBs to be paid substantially less than 100% of their "reasonable costs" did not violate statutory authority. The fact that Congress provided that government pay 80% of reasonable provider costs did not, according to the *Haynes* court, necessarily mandate that the states pay the remaining 20% in full. "Of course, Congress could mandate that 100% rather than 80% of a provider's bill be paid by the states in situations where patients do not make any part of the 20% supplemental contribution; it

has not done so." *Id.* at 593. The Court in *Haynes* criticized the *Perales* majority for relying on legislative history that relates not to Part B services, but to Part A inpatient hospital care. At bottom, the *Haynes* court adopted the reasoning in Judge Cardamone's dissent to the *Perales* opinion. "A pure Medicare beneficiary is entitled to Part B services because he or she pays the enrollment premiums; a dual eligible [QMB] is entitled to such services because – by virtue of his or her status as a Medicaid recipient – the state pays the enrollment premiums." *Haynes* at 594, citing *Perales*, 954 F.2d at 866 (Cardamone, J., dissenting). That Medicaid pays the enrollment premiums for certain Medicare Part B beneficiaries was sufficient for the *Haynes* court and the *Perales* dissent to condone different treatment of those beneficiaries through cost-sharing up to the Medicaid rate rather than the Medicare rate.[9]

This Court is persuaded by the reasoning in *Perales* and finds that the Medicaid rate limitation violates the Medicare and Medicaid Acts. The buy-in provisions of Medicaid clearly mandate that the state provide "medical assistance . . . for medicare cost-sharing for qualified

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[9] Plaintiff has called to the Court's attention the recent decision in *Pennsylvania Medical Soc'y v. Snider*, No. 1:CV-92-0481 (M.D. Penn. Nov. 2, 1993). In *Snider*, the district court found that Pennsylvania's Medicare cost-sharing scheme for QMBs, a scheme very similar to the rate limitation at issue in the instant case, did not violate the Medicare or Medicaid Acts. The *Snider* court's reasoning essentially echoes that in the *Haynes* decision. This Court declines to follow the *Snider* ruling for the same reasons it finds *Haynes* unpersuasive.

medicare beneficiaries . . . " § 1396a(a)(10)(E). Cost-sharing is defined as Part B premiums, deductibles and the difference between the amount paid by Medicare (80%) and "the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'." § 1396d(p)(3). Despite the seemingly permissive language in § 1396a(n), "A statute requiring Medicaid funds to be made available for Medicare cost-sharing can only sensibly be read as requiring the funds to be made available to cover *all* Medicare cost-sharing." *Perales* at 859. Plaintiff's motion on the issue of the illegality of the Medicaid rate limitation imposed by Virginia Plan Amendment 90-29 will be granted.

It necessarily follows that the prohibition placed by the *Perales* court on any limitation of therapy providers' right to recover their full reasonable costs or charges must also invalidate the direct billing amendments to the Virginia Plan. As heretofore discussed, the Medicare Act requires that the state pay the coinsurance on behalf of QMBs, payments that would ordinarily be exacted directly from the individual. It cannot be said that Congress contemplated payment to therapy providers indirectly through per diem prospective rates to nursing facilities when it defined cost-sharing as follows:

> (3) The term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

* * *

> (D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

§ 1396d(p)(3). Clearly, the rehabilitation agencies "incur costs" "with respect to a QMB" when they provide therapy services to QMBs in nursing facilities. The cost-sharing, therefore, must be paid directly and without regard to any distinction between "pure" QMBs and dual eligibles. Accordingly, the Court is of the view that it must grant plaintiff's motion on the illegality of the direct billing prohibition.

In conclusion, the buy-in provisions of § 1396a(a) require that Medicaid provide for making medical assistance available for medicare cost-sharing for QMBs. § 1396a(a)(10)(E). Moreover, the language of § 1396d(p)(3) indicates the state's obligation to bring a provider's reimbursement to the full 100% level.

> The apparent meaning of this section is that the states that participate in Medicaid must allocate Medicaid funds to the enrollment of all dual eligibles and QMBs in Part B of Medicare and to the payment of 20% of the reasonable costs or charges along with the annual deductibles incurred in this program.

Perales at 859. These sections read together and as interpreted by the *Perales* court lead ineluctably to the conclusion that the Virginia Plan amendments frustrate a

provider's right, under the Medicare Act, to collect reasonable costs and charges.

The practical effect of the Virginia Plan Amendments is to reimburse therapy providers less than their reasonable costs and charges solely by virtue of the economic status of the beneficiaries for whom they provide therapy services. "Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. These groups are the subject of this appeal, and such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act." *Perales* at 859. While the Commonwealth's asserted goal of reducing billing abuses is both worthy and required by statute, it cannot lawfully accomplish this goal by creating two reimbursement systems within the unitary Medicare program.

An appropriate Order will issue.

/s/ Robert R. Merhige, Jr.
UNITED STATES
DISTRICT JUDGE

Date _____

U.S. Department of Justice

(Seal)
BCB:RAOlderman **(202) 514-1838**

Washington, D.C. 20530

March 10, 1995

Mr. Bert M. Montague
Clerk, United States Court of Appeals
for the Fourth Circuit
1100 East Main Street
Fifth Floor
Richmond, VA 23219

Re: *Rehabilitation Association of Virginia, v. Kozlowski, (4th Cir. Nos. 93-2572, 94-1134)*

Dear Mr. Montague:

The Commonwealth of Virginia has moved to recall and stay the mandate in Nos. 94-1134 and 93-2572. This Court has ordered the parties in the case to respond to this motion by March 14, 1995. The Secretary of Health and Human Services, the appellant in No. 94-1134, files this response.

Both the Commonwealth and the United States are presently considering whether this case warrants further review in the Supreme Court of the United States. While the issuance of the court of appeals' mandate will not destroy the power of the Supreme Court to review the judgment at issue, we agree with the Commonwealth that recalling the mandate, and staying the issuance for a period of 30 days, would be prudent. Under Rule 41(b),

Federal Rules of Appellate Procedure, a stay of the mandate for a thirty day period pending certiorari is permitted; if a petition for a writ of certiorari is thereafter filed, the stay continues in effect until the Supreme Court disposes of the issue.

This case involves very complex issues of Medicare and Medicaid law. The importance of the issues, and their complexity, was recognized by the majority in its decision in this case, and by the dissent as well. The dissent's lengthy and insightful opinion in support of the position of the Commonwealth and the federal government is evidence that a petition for a writ of certiorari would not be frivolous or filed for delay, but that, to the contrary, the petition would present a substantial question for Supreme Court review. Thus, Local Rule 41.2, requiring that a motion for a stay of mandate present a substantial question and not be frivolous, is easily met in this case.

Respectfully submitted,

/s/ Richard A. Olderman
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42 U.S.C. § 1983. Civil action for deprivation of rights.

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1396a. State plans for medical assistance

(a) **Contents.** A State plan for medical assistance must –

(10) provide –

(E)(i) but, [sic] for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3) [42 U.S.C. § 1396d(p)(3)]) for qualified medicare beneficiaries described in section 1905(p)(1)[42 U.S.C. § 1396d(p)(1)];

(13) provide –

(A) for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

(30) (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the

extent that such care and services are available to the general population in the geographic area;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; . . .

42 U.S.C. § 1396a(b). Approval by Secretary. The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), . . .

42 U.S.C. § 1396a(n). Payment amounts. In the case of medical assistance furnished under this title [Medicaid] for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. § 1396c. Operation of State plans. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title [Medicaid], finds –

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [42 U.S.C. § 1396a]; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396d. Definitions. For purposes of this title [Medicaid] –

(a) Medical assistance. The term "medical assistance" means payment of part or all of the cost of the following care and services . . . (13) . . . rehabilitative services . . . .

(p) Qualified medicare beneficiary; medicare cost-sharing.

(1) The term "qualified medicare beneficiary" means an individual –

(A) who is entitled to hospital insurance benefits under part A of title XVIII [Medicare] (including an individual entitled to such benefits pursuant to an enrollment under section 1818 [42 U.S.C. § 1395i-2], but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A [42 U.S.C. § 1395i-2a]),

(B) whose income (as determined under section 1612 [42 U.S.C. § 1382a] for purposes of the supplemental security income program, except as provided in paragraph (2)(D) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1613 [42 U.S.C. § 1382b] for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A [42 U.S.C. § 1395i-2 or 1395i-2a], and

(ii) premiums under section 1839 [42 U.S.C. § 1395r], [.]

(B) Coinsurance under title XVIII [Medicare] (including coinsurance described in section 1813 [42 U.S.C. § 1395e]).

(C) Deductibles established under title XVIII [Medicare] (including those described in section 1813 and section 1833(b) [42 U.S.C. §§ 1395e and 1395l[b]).

(D) The difference between the amount that is paid under section 1833(a) [42 U.S.C. § 1395l(a)] and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876 [42 U.S.C. § 1395mm].

42 C.F.R. Ch. IV § 410.150. To whom payment is made.

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

(7) To a clinic, rehabilitation agency, or public health agency on the individual's behalf for outpatient physical therapy or speech pathology services furnished by the clinic or agency . . . .

PENNSYLVANIA MEDICAL SOCIETY DR. JAMES B. REGAN, M.D., Plaintiffs v. KAREN F. SNIDER, Individually and in her official capacity as Secretary of Public Welfare, and DONNA E. SHALALA, Secretary of the U.S. Department of Health and Human Services, Defendants

PENNSYLVANIA MED. SOCY. v. SNIDER

CIVIL ACTION NO. 1: CV-92-0481

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

1993 U.S. Dist. LEXIS 19613

November 2, 1993, Decided
November 2, 1993, Filed

JUDGES: RAMBO

OPINION BY: SYLVIA H. RAMBO

OPINION: MEMORANDUM

Background

Before the court are the motions and cross-motions for summary judgment of all the parties to this action. Plaintiffs are a Pennsylvania non-profit membership organization of providers of physician medical services and a practicing physician. Defendants are the Secretary of Public Welfare for the Commonwealth of Pennsylvania and the Secretary of the United States Department of Health and Human Services. Plaintiffs brought this action to challenge Pennsylvania's scheme for reimbursing physicians for services provided to a class of beneficiaries known as "Qualified Medicare Beneficiaries" (hereinafter "QMBs") under the Medicare cost-sharing provision of the Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(E)(i). The

action calls into question certain interrelated provisions of the two principal medical insurance programs enacted under the Social Security Act: the Medicare Act, 42 U.S.C. §§ 1395 et seq. (Title XVIII of the Social Security Act); and the Medicaid Act, 42 U.S.C. §§ 1396 et seq. (Title XIX of the Social Security Act). Because the issue before the court is purely one of statutory interpretation, the court will set forth the statutory framework relevant to the dispute between the parties.

I. Pertinent Medicare Provisions

Under the Medicare program, 42 U.S.C. §§ 1395 et seq., the federal government funds certain medical insurance for persons 65 years and older and for certain disabled persons, without regard to financial income. Insurance coverage under Medicare is provided through two distinct programs: Medicare Part A, pursuant to which the government pays the premiums for insurance coverage that provides full reimbursement to hospital and other institutional providers for certain services; and Medicare Part B, pursuant to which persons who are Medicare-eligible may obtain additional insurance at a cost to them, for certain physician and outpatient services not covered by Medicare Part A. It is primarily the voluntary insurance program provided through Medicare Part B that is relevant to the instant action.

Persons who elect to obtain Part B coverage must pay a set monthly premium, a deductible, and a portion of the fee due for each provided medical service. 42 U.S.C. § 1395cc(a)(2)(A). Part B insurance plans are administered

through local insurance carriers; in Pennsylvania, Pennsylvania Blue Shield is the primary carrier. See Joint Stipulation of Facts And Appendix of Documents In Connection with Cross Motion for Summary Judgment (hereinafter "Joint Stipulation"), P 6. Providers of Part B services are paid pursuant to a set "fee schedule amount." With respect to physicians' services, the fee schedule amount for any given service is set by the local Part B carrier in accordance with a national fee schedule which reflects amounts customarily charged in various geographical areas for particular services. See 42 U.S.C. § 1395w-4(a)(1). The individual Part B beneficiary must exhaust a $100.00 deductible, after which Medicare ordinarily will pay 80% of the fee schedule amount for any given physicians' service. 42 U.S.C. § 1395l(a)(1)(N). The physician provider may then bill the individual Part B beneficiary for 20% of the "reasonable charge" for such services, which amount may not exceed 20% of the amount customarily charged by the provider. See 42 U.S.C. § 1395cc2(A). This 20% amount is known as the Part B beneficiary's "coinsurance payment."

In 1989, Congress amended the Medicare Act to require that physicians accept the Medicare fee schedule payment as full payment for services to Medicare-enrolled QMBs, thereby prohibiting the billing of QMBs for amounts in excess of Medicare's 80% fee schedule payment. 42 U.S.C. § 1395-w-4(g)(3)(A). Although the provision did not concern QMBs whose enrollment in Medicare was financed by Medicaid, the legislative history reveals that in arriving at their decision to forbid balance billing of non-Medicaid funded QMBs, Congress

looked to current practices in the states regarding Medicaid-funded QMBs:

> The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question. . . . The [proposed bill] would amend current law to require that physicians take assignment under Medicare for all services furnished to dual eligibles and [QMBs] (if such services are also covered under the Medicaid program in the state). Thus, it codifies current practice with respect to dual eligibles and extends it to [QMBs]. It does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims.

H. Rep. No. 247, 101st Congress, 1st Sess., reprinted in 1989 U.S.C.C.A.N. 1906, 2090.

II. Pertinent Medicaid Provisions

Under the Medicaid Act, 42 U.S.C. §§ 1396 et seq., the federal government and the individual states jointly fund a medical insurance program, which is administered by the state, for persons who are financially needy as defined by the statute. There is no age limit to participation in a state's Medicaid program. If a state wishes to establish a Medicaid program, it must submit a State Medical Assistance Plan to the United States Secretary of Health and Human Services, who reviews it for compliance with Health and Human Services, who reviews it for compliance with Medicaid statutory and regulatory guidelines. 42 U.S.C. § 1396a(a)-(b). If the Secretary

approves the State Medical Assistance Plan, the federal government will provide funds, known as "federal financial participation" ("FFP"), to the state to administer its Medicaid program. Providers of medical services to Medicaid beneficiaries are reimbursed pursuant to a fee schedule that is set forth in the state's Medical Assistance Plan. Medicaid providers may not seek more than the specified Medicaid rate, regardless of whether it is lower than their customary rate; Medicaid rates are typically lower than the provider's customary charge for the rate. Joint Stipulation, P 11. Medicaid beneficiaries pay no premium or deductible. Under Pennsylvania's plan, however, they may be required to pay a coinsurance payment between the amounts of $.50 and $3.00, depending upon the service provided. 55 Pa. Code § 1101.

III. Qualified Medical Beneficiaries

Qualified Medical Beneficiaries ("QMBs") are persons who are entitled to Medicare because of age, and whose income and assets fall below a certain level. QMBs may or may not be eligible for Medicaid as well as Medicare; the income levels qualifying a person for Medicaid and QMB status are not the same. The QMB income level is tied to the official federal poverty line. See 42 U.S.C. § 1396d(p)(1)-(2). The basic income and assets levels entitling persons to participate in Pennsylvania's Medicaid program are lower than those affording QMB status. Joint Stipulation, § 15. As noted supra, at pp. 3-4, in 1989, Congress amended the Medicare Act to require that physicians accept the Medicare fee schedule payment as full payment for services to non-Medicaid funded

QMBs enrolled in Medicare. 42 U.S.C. § 1395-w-4(g)(3)(A).

Certain provisions of the Medicaid Act mandate the components to be included in a state's Medicaid Plan; these include a provision requiring states to provide Medicaid funds for cost-sharing of certain Medicare services to QMBs. 42 U.S.C. § 396a(a)(10)(E). Medicare Part B services, which are in addition to services available through Medicaid, now must be made available to QMBs. The premiums, deductibles, and coinsurance payments for such services are to be handled through the state's Medicaid plan; in return, the Medicare program pays providers the usual Medicare reimbursement, that is, 80% of the Medicare fee schedule. 42 U.S.C. § 1396a(a)(10)(E)(i); Joint Stipulation, P 13. The Medicaid Act further provides that states may implement a plan wherein the state Medicaid plan pays the coinsurance and deductible for a Medicare cost-sharing QMB even if, when such payment is added to Medicare's 80% of fee schedule reimbursement, the total payment for a service will exceed that ordinarily paid under Medicaid fee schedules. 42 U.S.C. § 1396a(n).

Pennsylvania has implemented the Medicare cost-sharing requirements for QMBs into the state Medicaid plan as follows: and Medicaid pays the premiums. Joint Stipulation, P 13. Cost-sharing for deductibles and co-insurance payments are made in accordance with the following regulation:

> If a [Medicaid] recipient also has Medicare coverage, the Department [of Public Welfare] may be billed for charges that Medicare applied to the deductible or coinsurance, or both. Payment

> will be made in accordance with established [Medicaid] rates and fees.

55 Pa. Code § 1101.64(b). In accordance with this regulation, Pennsylvania's "Medical Assistance Handbook" explains that Medicaid will reimburse physicians for Medicare Part B services to QMBs only if the Medicare reimbursement received by the physician (i.e., 80% of the Medicare fee schedule amount) is less than the maximum amount that Pennsylvania Medicaid reimburses for the service. In practice, the Medicare reimbursement amount is virtually never less than Pennsylvania's Medicaid reimbursement amount and, therefore, physicians typically receive no additional payment for Medicare Part B services to QMBs over and above the 80% of Medicare fee schedule. Joint Stipulation, PP 20-21. The Secretary of Health and Human Services has approved this Medicare cost-sharing arrangement. Thus, the court has arrived at the issue in this dispute: Does Pennsylvania's Medicare cost-sharing arrangement with respect to Medicare Part B services for QMBs violate the Medicare and/or Medicaid Acts by failing to guarantee that physicians will be reimbursed in the same amount that they are reimbursed for services to non-QMB Medicare Part B beneficiaries?

Discussion

The court's analysis starts from the premise that courts must afford considerable weight to the interpretation given a statute by the agency charged with its implementation. Chevron USA, Inc. v Natural Resources Defense Council, Inc., 467 U.S. 837, 844, 81 L.Ed.2d 694, 104 S.Ct. 2778 (1984). If Congress has spoken directly to

the disputed issue, and the agency has given effect to the unambiguously expressed intent of Congress, so must the court. Id. at 842. If the statute is silent or the language is ambiguous, the only question for the court is whether the agency's interpretation is a reasonable construction of the statute. Id. at 842-43. In this case, there is considerable support for holding that Congress has unambiguously stated that states shall decide whether and how much to reimburse physicians above the Medicare fee schedule payment for services provided to Medicaid-funded QMB enrollees in Medicare Part B.[1] In the event that reasonable minds might disagree as to that holding, however, this court will treat the statutory language as though it is silent or ambiguous, and go on to determine whether the agency interpretation given to it is reasonable.

The parties memoranda in support of their cross-motions for summary judgment discuss at some length the legislative history pertinent to the Medicaid Act provisions setting up the obligation of state Medicaid plans to fund Medicare cost-sharing for QMBs. The court does not perceive much room for argument: The language of the Medicaid Act, 42 U.S.C. § 1396a(n) and the pertinent legislative history,[2] demonstrate that in mandating that state Medicaid plans to fund Medicare Part B coverage for QMBs, Congress knew that the coinsurance reimbursement normally paid to physicians by non-QMB participants in Medicare Part B might go unpaid in the case of

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[1] See 42 U.S.C. §§ 1395-w-4(g)(3)(A) and 1396a(n), set forth in this Memorandum, supra at 3-4, & 6, respectively.

[2] See Defendants' Memorandum in Support of Cross Motion for Summary Judgment, at 5-11.

QMBs. This prospect of a limit on the amounts that physicians can collect from Medicaid for QMBs is entirely consistent with the outright limit imposed against collection from QMBs and Medicaid recipients themselves, as well as the outright payment limits imposed with respect to Medicaid-covered services. Both classes of patients are financially disadvantaged. Congress mandated that the state and the federal government must provide a certain amount of assistance to these patients, but sensibly permitted the states some leeway with respect to their payment obligations.

Plaintiffs rely upon New York City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir. 1992), in which the Second Circuit Court of Appeals held that a substantially similar Medicare cost-sharing scheme under New York State's Medicaid plan violated the Medicare and Medicaid Acts. Reviewing the language of Sections 1396a(a)(10) and 1396a(n) of the Medicaid Act,[3] the Perales court declared that a statute that required Medicaid funds to be made available for Medicare cost-sharing could make sense only if it required Medicaid's payment of all Medicare cost-sharing. Perales, 954 F.2d at 859. In the Perales' court's view, Section 1389a(n) was included simply to reassure physicians that they were not prohibited from accepting more than the Medicaid rate for Medicare cost-shared services. Id. The Defendants in the Perales case argued, in part, that QMB cost-sharing beneficiaries were primarily Medicaid patients and, as with other financially disadvantaged individuals, providers

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[3] These provisions are set forth in the court's discussion of the statutory provisions relevant to QMBs, supra.

are not necessarily entitled to full compensation for their reasonable costs or charges. Perales, 954 F.2d at 858-59.

This court finds that the Perales court's reasoning is unpersuasive. The language of § 1396a(n) is permissive and not mandatory with respect to a state's reimbursement for Medicare cost-sharing in excess of its own Medicaid fee schedule. Furthermore, this court does not share the Second Circuit's view of what makes sense with respect to a joint federal/state initiative designed to extend additional medical services to financially disadvantaged persons. In stating that cost-sharing can make sense only if it required Medicaid's payment of all Medicare cost-sharing, the Perales court implies that cost-sharing makes sense only if physicians receive the same payment that they receive for services to non-financially disadvantaged participants in Medicare Part B. The argument completely disregards Congress' recognition of the special circumstances of financially disadvantaged Medicare participants, which is plainly revealed in the 1989 prohibition against balance billing of QMBs. Furthermore, it does not make sense to acknowledge that when Congress amended the Medicare Act to preclude the balance billing of non-Medicaid funded QMBs, it referred approvingly to the states' practice of paying an amount only up to Medicaid fee schedule payments for Medicaid-funded QMBs,[4] but to argue that Congress did not intend for states to engage in that very practice.

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[4] See 42 U.S.C. § 1395-w-4(g)(3)(A), discussed supra, at pp. 3-4.

Nor does this Court agree that cost-sharing QMBs should be viewed primarily as Medicare patients. The fact is, over 99% of Pennsylvania's QMBs are Medicaid patients. The remaining fraction of a percent of QMBs have incomes no higher than the federally calculated poverty level, although they may have personal assets somewhat higher than other QMBs. Joint Stipulation, PP 16-18. Moreover, the relevant Medicare cost-sharing and QMB provisions were enacted as amendments to the Medicaid Act, and not to the Medicare Act. When considered in light of the successive amendments that culminated in Congress mandating that state amendments that culminated in Congress mandating that state Medicaid plans provide for Medicare cost-sharing for QMBs, it makes sense to interpret § 1396a(n) as permitting states to limit its obligation to the Medicaid fee schedule if Medicare's 80% fee schedule figure is lower than Medicaid's payment.

The district court in Haynes Ambulance Serv. v. State of Ala., 820 F. Supp. 590 (M.D. Ala. 1993) also found the Perales court's reasoning unpersuasive. There, addressing a challenge to Alabama's Medicare cost-sharing scheme, the court said:

> The Court finds it difficult to understand, particularly in the face of Congressional silence, why the states must swallow the portion of provider costs to poor Medicare recipients that exceed the 80% mandated by Congress. It is logical acrobatics to determine that Congress "unambiguously" decreed that government would pay 100 percent of such costs to providers for QMBs simply because Congress provided that government pay 80 percent of

> reasonable provider costs for Medicare beneficiaries with the right given to the provider to collect the remaining 20 percent from the supplemental insurance paid for by the Medicare beneficiary who is able to pay for such insurance.

Haynes, 820 F. Supp. at 593. The Haynes court found it telling that there was no specific statutory mandate to states to pay the additional 20% coinsurance charge for Part B services to QMBs, while there is a specific mandate to states to pay equally for Part A services for QMBs and ordinary Medicare beneficiaries. Id. at 594 & n.5. The Haynes court further relied upon the language from the Senate Report accompanying the initial enactment of the Medicare Act, which reflected distinctly different approaches to payment of Medicare Part A and Part B deductibles and coinsurance payments:

> The [Part A] hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with . . . hospital benefits.
>
> * * *
>
> A state medical assistance plan may provide for the payment in full of any deductibles or cost-sharing under the insurance program established by Part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources. . . .

Id. at 594 n.5 (quoting S. Rep. No. 404, 89th Cong. 1st Sess. 27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 2020)

(emphasis added). In the view of the Haynes court and of this court, the continuing mandatory approach to payment of Part A deductibles, considered in light of the lack of specific mandate for full payment of Part B coinsurance payments, and the permissive language of § 1396a(a)(10)(F) demonstrates that Congress intended to permit states to decide how to reimburse physicians for Medicare Part B services to QMBs.

In an era of concern over state and federal fiscal well-being and the availability of quality health care for the poor and elderly, it seems quite sensible to presume that Congress placed responsibility for Medicare cost-sharing for QMBs upon state Medicaid plans with the intention of making it permissible that physicians would be reimbursed only up to the Medicare 80% of fee schedule figure, or the Medicaid amount, whichever was higher. It is reasonable to believe that Congress meant to allow states to restrict the amount physicians can collect as reimbursement for certain services to QMBs, just as they are restricted with respect to the amounts they can collect for services to Medicaid patients. The court sees no violation of the statutory scheme in Pennsylvania's Medicare cost-sharing scheme for QMBs. Accordingly, the court will grant summary judgment in favor of Defendants on this issue.[5]

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[5] Plaintiffs' complaint requests a declaratory judgment that the Medicare cost-sharing scheme violates 42 U.S.C. § 1983 as well. The § 1983 claim has not been supported or argued in any fashion and the court is unaware of a possible basis for § 1983 relief in these circumstances.

Plaintiffs also request a declaration that the cost-sharing scheme violates § 1394v(f) of the Medicare Act because Pennsylvania has failed to devise a single claims processing arrangement in conjunction with its local insurance carrier, Pennsylvania Blue Shield. The applicable statutory language, which the parties agree pertains to agreements between a state and federal government to enroll Medicaid recipients and QMBs in Medicare through cost-sharing,[6] is as follows:

> The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI . . . and individuals eligible to receive medical assistance under the plan of the State approved under title XIX (42 U.S.C. § 1396 et seq.].

42 U.S.C. § 1395v(f).

Plaintiffs are discontent with the progress made by the Department of Public Welfare and the Department of Health and Human Services in implementing a computerized single-claim system that would allow submission of one claim to suffice for payment of both Medicare and Medicaid reimbursements due for services to QMBs.

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[6] These agreements are commonly referred to as "buy-in" agreements. See Defendants' Memorandum in Support of Cross Motion for Summary Judgment, at 40-41.

It is apparent from the submissions of the parties that the State has considered implementing such a system and that the United States Senate Finance Committee hearings included statements suggesting that such a merged payment procedure is preferable. There is, however, nothing to support that the notion that a single-claims system is the only one that can satisfy § 1395v(f)'s directive that a claims handling system lead to "economy and efficiency of operation." Neither the statutory language nor the legislative history suggests that the lack of a computerized single claims should lead a court to invalidate a state's buy-in agreement. This court is not the appropriate forum for seeking to impose a particular computerized claims handling scheme upon an administrative agency. The power to make discretionary, policy-based decisions about intra-organizational administration lies properly with the agency or the legislative branch of government, and not with the courts, absent a very clear statutory mandate to the contrary. See generally, Chevron, U.S.A., Inc. v. NRDC, 467 U.S. at 837; Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 67 L.Ed.2d 694, 101 S.Ct. 1531 (1981).

As a practical matter, Plaintiffs' § 1395v(f) claim is also perplexing because it is aimed at claims for which Medicaid reimbursement rates exceed the Medicare reimbursement rates, in which case physicians must submit a claim first to Pennsylvania Blue Shield, and then to the Department of Public Welfare. Those instances, the parties have stipulated, are extremely rare. Finally, Plaintiffs assert without support the notion that § 1395v(f)'s "economy and efficiency of operation" goal was inserted for the benefit of physicians. The court questions whether the

Plaintiffs have standing to demand the implementation of a particular claims handling scheme; in any case, the court does not believe that Pennsylvania's buy-in agreement violates 42 U.S.C. § 1395v(f). Summary judgment will be granted to the Defendants on that issue as well. An appropriate order will be entered.

SYLVIA H. RAMBO, Chief Judge

Middle District of Pennsylvania

Dated: November 2, 1993.

HAYNES AMBULANCE SERVICE, INC., a corporation; City Ambulance of Alabama, Inc., a corporation; Med Star Ambulance Service, Inc., a corporation; Suburban Ambulance Service, Inc., a corporation; Emergency Service, Inc., a corporation; Hank's Ambulance Service, Inc., a corporation; A & A Ambulance Service, Inc., a corporation; Regional Paramedical Service, a corporation; Newman's Medical Service, a corporation; and Community Ambulance Service, Inc., a corporation, individually and for and on behalf of a class of persons or entities providing services to recipients of Medicare and Medicaid benefits as is more particularly referred to in this complaint, Plaintiffs,

v.

STATE OF ALABAMA; Guy Hunt as Governor of the State of Alabama; Alabama Medicaid Agency, an agency of the State of Alabama; Carol Merrman, as the Commissioner of the Alabama Medicaid Agency; and Donna E. Shalala as the Secretary of the Department of Health and Human Services, an agency of the United States of America, Defendants.

Civ. A. No. 92-H-879-N.

United States District Court,
M.D. Alabama, N.D.

April 16, 1993.

Owners and operators of ambulance services treating qualified Medicare beneficiaries brought action against Secretary of Health and Human Services, Commissioner of Alabama Medicaid Agency, Alabama Medicaid Agency, Alabama, and Governor to challenge lack of

reimbursement for 100% of reasonable costs. Defendants moved for summary judgment. The District Court, Hobbs, J., held that providers of outpatient medical care to qualified Medicare beneficiaries (QMBs) are not entitled to 100% of their reasonable costs under Part B.

Motion granted.

Jack G. Paden, Bessemer, AL, and Thomas C. Najjar, Jr. and Jesse P. Evans III, firm of Najjar Denaburg, Birmingham, AL, for plaintiffs.

Stuart M. Gerson, Asst. Atty. Gen., Washington, DC, James Eldon Wilson, U.S. Atty., Kenneth E. Vines, Asst. U.S. Atty., Montgomery, AL (David Smith, Office of Gen. Counsel, Dept. of Health and Human Services, Sheila M. Lieber, Pleadings signed by Peter D. Coffman, Attys., Dept. of Justice Civ. Div., Federal Programs, Washington, DC of counsel), for Shalala as Secretary of Dept. of Health and Human Services.

Graddick & Belser, David E. Belser and Charles A. Graddick, Montgomery, AL, for State of AL and Guy Hunt.

William O. Butler, III, AL Medicaid Agency, Montgomery, AL, for AL Medicaid Agency and Herrman, as Com'n.

MEMORANDUM OPINION

HOBBS, District Judge.

I. INTRODUCTION

Plaintiffs, owners and operators of ambulance services,[1] are providers to Medicare and Medicaid recipients in the state of Alabama. Plaintiffs have challenged a regulation of the Alabama Medicaid Agency, which plaintiffs contend illegally restricts the amount of recovery to plaintiffs for services which they provide to poor Medicare patients, such restriction allegedly being in violation of a federal statute. The Court concludes that the challenged regulation does not violate the applicable statute, 42 U.S.C. § 1396a.

Defendant Alabama Medicaid Agency is an agency of the State of Alabama and administers programs and benefits under the Medicare and Medicaid Acts. Defendant Donna E. Shalala is Secretary of the United States Department of Health and Human Services. Shalala is authorized to administer Medicare and Medicaid programs at the request of the Alabama Medicaid Agency. Defendant Carol Herrman is the acting Commissioner of the Alabama Medicaid Agency. Herrman has general supervisory control of the agency including the administration of reimbursement programs under the Medicare and Medicaid Acts. As Governor of Alabama, defendant Guy Hunt is charged with the execution and enforcement of the laws of Alabama.

A. Medicaid

Medicaid is a cooperative federal-state matching program which subsidizes medical care for the needy

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[1] *See* 42 CFR § 410.40.

without regard to the recipient's age. Each participating state designs and administers its own Medicaid program within federal guidelines. If the program is approved by the Secretary of Health and Human Services, the state receives federal funds to help finance the program.

B. Medicare

Under Part A of the Medicare program, which is federally funded, individuals who are 65 years of age and older, and certain disabled persons under age 65, are fully reimbursed the "reasonable cost" for inpatient hospital care without regard to the individual's economic status. 42 U.S.C. §§ 1395c-1395i-4. Part B of the Medicare program is a voluntary insurance program which allows Medicare-eligible individuals, who are financially able, to obtain supplemental insurance for outpatient medical care. 42 U.S.C. §§ 1395j-1395w-4(j). If an individual qualifies for Part B coverage by obtaining supplemental insurance, the federal government pays for 80 percent of "reasonable costs" charged to the recipient. The recipient is responsible for paying the remaining 20 percent, (the "coinsurance amount") and any annual deductible.

C. Qualified Medicare Beneficiaries

Under federal law, a state "may" agree to pay Part B Medicare insurance premiums for individuals who qualify for Medicare based on age and who have incomes at or below the poverty line. 42 U.S.C. § 1396a(n). Such beneficiaries, who must meet the resource and income

limit set forth in 42 U.S.C. § 1396d(p)(1), are designated "qualified Medicare beneficiaries" (QMBs).[2]

The question in this lawsuit is what payment is due the providers of outpatient medical care where the state does not provide supplemental insurance. The Alabama plan, except in rare circumstances, allows such providers only 80% of their reasonable costs; the providers contend that the states must pay 100% of such costs.

II. BACKGROUND

The state of Alabama has obtained approval of a State Medical Assistance Plan from the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1396a. Under the Alabama plan providers for QMBs almost never collect more than 80 percent of their "reasonable costs."

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[2] In *New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992) and *Samuel v. California Dept. of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), cases both discussed in this opinion, the terms "dual eligibles" and "crossovers" are used respectively to label those individuals eligible for Medicare as well as Medicaid. The term "qualified Medicare beneficiary" was introduced to the Medicaid Act as part of the Act's 1986 amendments and is adopted here for the sake of uniformity. The House Conference Report to the Technical and Miscellaneous Revenue Act of 1988 specifies that all Medicare-eligible persons with resources under the limits called for in 42 U.S.C. § 1396d(p)(1) are to be considered QMBs "whether or not they are otherwise eligible for Medicaid." H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess., reprinted in 1988 U.S.C.C.A.N. 4515, 5048, 5344.

Plaintiffs[3] bring this action under the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc, and the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.*, claiming that as with Medicare beneficiaries who elect to purchase supplemental insurance, providers are entitled to receive 100% of their "reasonable costs" when providing such services to those who have no supplemental insurance such as QMBs.

The parties have agreed that there are no factual disputes on the issue of the proper amount owing providers for the treatment of QMBs pursuant to the Medicare and Medicaid Acts respectively. The parties also agree that the answer is based solely on the applicable statutes. Accordingly, the Court has decided this issue based on cross-motions for summary judgment after considering the briefs of the parties.

As noted, the Court concludes that the Alabama Medicaid Agency is reimbursing health care providers who render Part B services to QMBs at a rate which comports with statutory authority, and that defendants are entitled to prevail on their motions for summary judgment.

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[3] Although plaintiffs originally sought to bring a class action, defendants agreed that they would be bound by any ultimate judicial decision in this case as to all potential class members. Accordingly, it was agreed in order to simplify the case, which all parties acknowledged was a matter of statutory interpretation, that plaintiffs would withdraw their request to bring this case as a class action.

III. DISCUSSION

The sole issue presented in this litigation is whether the Alabama State Medical Assistance Plan violates 42 U.S.C. § 1396a when it directs that providers treating QMBs will be paid substantially less than 100% of their "reasonable costs."

The interpretation of a statute by the agency charged with its administration is entitled to "considerable weight." *Chevron USA Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782-83, 81 L.Ed.2d 694 (1984); *Rust v. Sullivan*, ___ U.S. ___, ___, 111 S.Ct. 1759, 1767, 114 L.Ed.2d 233 (1991) (Secretary's construction must be accorded substantial deference as the interpretation of the agency charged with administering the statute). Where agency interpretation is in a complex area, it should be upheld if it is reasonable and permissible. *Southern Motor Carriers Rate Conference v. United States*, 773 F.2d 1561, 1567 (11th Cir.1985) (citing *Chevron*, 467 U.S. at 843-46, 104 S.Ct. at 2781-84). In the case at bench, deference to the Secretary is particularly applicable since she is charged with administering legislation which "is among the most intricate ever drafted by Congress." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43, 101 S.Ct. 2633, 2640, 69 L.Ed.2d 460 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727 n. 7 (2d Cir.1976) *cert. denied* 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977)).

In *Chevron*, the Supreme Court adopted the following two-step test for determining whether an agency's construction of a statute which it administers is entitled to deference:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . If the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron, 467 U.S. at 842-43, 104 S.Ct. at 2781-82. *See also Curse v. Director, Office of Workers' Comp. Prog.*, 843 F.2d 456, 460 (11th Cir.1988); *Hussion Madigan*, 950 F.2d 1546, 1550-51 (11th Cir.1992).

1. Unambiguous Intent of Congress

The first inquiry under *Chevron*, as applied here, is whether Congress unambiguously intended that the states be required to pay providers of QMBS 100 percent of their reasonable charges or costs rendered for Part B services. Nothing in the Medicaid or Medicare statutes furnishes any evidence that Congress ever focused on what percentage of "reasonable" Part B provider costs should be borne by the states for QMBs. Although Congress expressly mandated that the states pay in full reasonable costs for *Part A* inpatient hospital services,[4]

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[4] The 1965 Senate Report covering the initial Medicare Act provides:

nowhere in the statute or accompanying legislation is there language decreeing that the states pick up the full tab for those obtaining *Part B* outpatient services.

Plaintiffs rely heavily on *New York City Health & Hosp. Corp. v. Perales,* 954 F.2d 854 (2d Cir.1992) in asserting that providers to QMBs are entitled to collect the state's full cost-sharing reimbursement in accordance with their reasonable costs or charges under the Medicare Act. It is plaintiffs' position that providers of benefits to QMBs should receive the same full payment for their benefits as providers would receive for rendering services to those who have independently paid for Part B Medicare benefits.

The Court finds it difficult to understand, particularly in the face of Congressional silence, why the states must swallow the portion of provider costs to poor Medicare recipients that exceed the 80% mandated by Congress. It is logical acrobatics to determine that Congress "unambiguously" decreed that government would pay 100 percent of such costs to providers for QMBs simply

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> No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan.
>
> Taken together, these provisions give assurance that *the hospital bill incurred by a needy individual shall be paid in full* under the provisions of the State plan . . . and that the States may not expect to require the individual to use his income or resources . . . toward that bill.

S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code & Cong. Admin. News 1943, 2019-20 (emphasis added).

because Congress provided that government pay 80 percent of reasonable provider costs for Medicare beneficiaries with the right given to the provider to collect the remaining 20 percent from the supplemental insurance paid for by the Medicare beneficiary who is able to pay for such insurance.

Plaintiffs' syllogism that because providers to Part B beneficiaries who are able to afford premiums receive 100 percent of their service charges, the same providers to those unable to make these payments are entitled also to collect their fees in full, impresses this Court as clearly not "the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 843, 104 S.Ct. at 2781. Moreover, it is not even remotely suggested in any statutory language. The argument that a provider is entitled to 100 percent of his charge to QMBs originates not from statute, but from ingenious and imaginative lawyering.

Apart from failing to recognize the inherent difference between Part A and Part B Medicare services, plaintiffs have ignored Congress' avoidance of imposing a cost on state welfare systems which are unable or unwilling to do so voluntarily. 42 U.S.C. § 1396a(n); H.R. Rep. No. 247, 101st Cong., 1st Sess., reprinted in 1989 U.S.C.C.A.N. at 1906, 2090; H.R. Rep. No. 105(II), 100th Cong., 2d Sess., reprinted in 1988 U.S.C.C.A.N. at 803, 884. Of course, Congress could mandate that 100% rather than 80% of a provider's bill be paid by the states in situations where patients do not make any part of the 20% supplemental contribution; it has not done so. It seems most illogical, however, that courts would ignore the statutory construction of the Secretary charged with administering the Act, and in the absence of any evidence that Congress

addressed the amount of the contribution of the government for such non-contributing beneficiaries, would impose a 100% payment on the states.

As with the plaintiffs here, plaintiff providers in *Samuel v. California Dept. of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), sought a declaration that the state's limitation on reimbursement to outpatient providers for services rendered to QMBs violated the federal statute. In rejecting plaintiffs' claim, *Samuel* held that the plain language of the statute did not place an affirmative duty on the state to pay 100 percent of provider costs for services rendered to QMBs.

The court in *Samuel* stated that the California plaintiffs erroneously presupposed that the intent of the statute in issue was to assure the health care provider full payment of Medicare costs incurred by a QMB. Citing legislative history, the *Samuel* court stated that the plaintiffs' presupposition ignored Congress' intent to protect the beneficiary rather than the provider. *Samuel*, 570 F. Supp. at 570.

In support of its argument that Congress intended QMB Part B health care providers to be reimbursed at the 100% level, which would be available with the individual Medicare beneficiary paying for the supplemental charges, plaintiffs cite the 1965 Senate Report accompanying the initial Medicare Act. S. Rep. No. 404, 89th Cong., 1st Sess. 27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1967-68. An examination of the 1965 legislative history, however, reveals that Congress' concern with a "two-tiered system of health care" applied to Part A inpatient hospital care, not to the Part B voluntary program. *See*

Perales, 954 F.2d at 867 (Cardamone, J., dissenting). As Judge Cardamone correctly observed in his dissent, Congress made a clear distinction between health care services covered under Part A and Part B.[5]

Judge Cardamone's analysis explains the important difference between Medicare patients who pay for supplemental insurance under Part B and QMBs who do not. While both QMBs and pure Medicare beneficiaries are entitled automatically to Part A services – inpatient hospital services – the voluntary and supplementary nature of Part B services precludes automatic entitlement. An outpatient provider is entitled to full payment of the "reasonable value" of the services under Part B only because the beneficiary has paid for supplemental insurance to cover 20% of the cost. This does not suggest,

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[5] Two consecutive paragraphs from the Committee Report offer a clear comparison between the mandatory approach to payment of deductibles for hospital care under Part A and the permissive approach for other services under Part B:

> The hospital insurance benefit program included under other provisions of the bill provides for a deductible which *must be paid* in connection with. . . . hospitalization benefits.
>
> * * *
>
> A state medical assistance plan *may* provide for the payment in full of any deductibles or cost-sharing under the insurance program established by Part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources . . .

S. Rep. No. 404, *supra*, 1965 U.S.C.C.A.N. at 2020 (emphasis added).

much less compel, the conclusion that if the services are rendered to one unable to pay the 20%, the state must pay it. Judge Cardamone explained:

> A pure Medicare beneficiary is entitled to Part B services because he or she pays the enrollment premiums; a dual eligible [QMB] is entitled to such services because – by virtue of his or her status as a Medicaid recipient – the state pays the enrollment premiums.

Perales, 954 F.2d at 866.

The 1965 Senate Report mandates that under Part A for the same inpatient services, states must pay equally for QMBs and pure Medicare beneficiaries. A comparable direction to the states is lacking regarding Part B charges. Section 9403 of the Budget Reconciliation Act of 1986, P.L. 99-509, 100 Stat. 2053 (1986), which constitutes the 1986 amendments to the Medicaid Act creating QMBs, echoes Congress' earlier recognition that the states could limit amounts owing to providers for outpatient services to QMBs to the Medicaid rate. Section 9403(c)(2) states that "the medical assistance made available to a qualified medicare beneficiary. . . . shall be limited to medical assistance for Medicare cost sharing. . . . subject to the provisions of subsection (n) of this section. . . . " 42 U.S.C. § 1396a(a)(10)(F). Subsection (n), in turn, provides:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may* provide payment in an amount with respect to the service or item that results in the sum of

> such payment amount and any amount of payment made under subchapter XVIII of this chapter [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. § 1396a(n) (emphasis added).

This permissive[6] language demonstrates that Congress did not intend that the states unconditionally be required to reimburse the QMB provider at a rate greater than the Medicaid rate. Indeed, rather than prescribing specific payment methodologies or rates, and consistent with the Medicaid Act's emphasis on flexible state assistance, Congress allowed states the freedom to design their own plans subject to federal approval.

This distinction between Part A and Part B qualification requirements, in tandem with Congress' silence on the states' Part B reimbursement responsibility to QMBs, does not allow this Court to ignore the construction of this complex statute by the Secretary charged with administering it, to order that providers be paid 100% of the reasonable value of their services to QMBs. The interpretation of the statute by the Secretary should not be overruled by the courts because courts may believe that it

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[6] When Congress intended to make it mandatory that state Medicaid agencies pay the coinsurance amount and deductibles for beneficiaries, it did so plainly. *See, e.g.* 42 U.S.C. § 1396e(a)(3) ("[each State plan] shall provide for payment of all enrollment premiums for such enrollment and all deductibles, coinsurance, and other cost sharing obligations. . . . ").

would be desirable if all providers were compensated at 100% of their costs.

2. Reasonable Construction

Having established that the Secretary's interpretation of the legislation in issue survives the initial *Chevron* inquiry, the Court's final focus turns to whether the Secretary's interpretation of the statute she is administering is reasonable.

Although the Court believes that the Secretary's interpretation of the statute is the correct interpretation, it need not be the only one which could have been adopted, or even that it be the preferred construction. *Pauley v. BethEnergy Mines, Inc.*, ___ U.S. ___, ___, 111 S.Ct. 2524, 2537, 115 L.Ed.2d 604 (1991) ("It is axiomatic that the Secretary's interpretation need not be the best or most natural one"). The sole determination is whether the Secretary's interpretation is reasonable. *Chevron*, 467 U.S. at 845, 104 S.Ct. at 2783. Absent "definitive contrary legislative command" reasonable agency interpretation should be upheld. *United States v. Fulton*, 475 U.S. 657, 666, 106 S.Ct. 1422, 1427-28, 89 L.Ed.2d 661 (1986). Here, the statute, on its face, does not mandate that providers to QMBs be reimbursed 100 percent for Part B services. Likewise, nothing in the legislative history commands the states to bear the entire burden of Part B provider costs.

The Court's finding that the Secretary's interpretation is reasonable is supported by a strong current of state flexibility which, as previously discussed, fashions the Medicaid Act. Because state funds available for public

assistance are limited, the states are granted latitude in establishing fees to be paid providers for Medicaid services. *See Schweiker v. Hogan*, 457 U.S. 569, 590, 102 S.Ct. 2597, 2609-10, 73 L.Ed.2d 227 (1982) ("federal government cannot finance a program that provides meaningful benefits in equal measure to everyone").

The Secretary has approved the Alabama Medicaid Agency's policy of limiting QMB provider reimbursement to the maximum Medicaid amount, rather than the Medicare rate supplemented by insurance paid for by the Medicare beneficiary who is financially able to pay for such insurance.

IV. CONCLUSION

No one questions that Congress can mandate that states pay to medical providers more than their resources can afford, and in order to get the carrot of the federal contribution, states can be required to take on payments to medical providers which devastate state budgeting at the expense of education and other governmental services.

Every year medical costs escalate at substantially greater rates than inflation. Medical costs now equal 14 percent of America's entire economy, an increase in the decade of the 1980s from 9.4 percent. The Commerce Department reports that health care costs climbed 12 percent in 1991, four times the rate of overall inflation. No one suggests that medical providers have suffered over the years from unreasonable caps on their charges.

Courts should not, at the instance of providers, construe Congressional silence to require states to shoulder added medical costs which neither the states, nor the federal agency charged with administering the federal statutes, believe are compelled by Congress.

An appropriate order shall issue.

DONE.

ORDER

Pursuant to an opinion filed contemporaneously herewith, IT IS ORDERED THAT:

1. Plaintiffs' Motion For Summary Judgment is DENIED;

2. Defendants' Motion For Summary Judgment is GRANTED.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, SIDNEY FINKEL, and JOHN A. BLESKI, Plaintiffs, v. CESAR A. PERALES, as Commissioner of Social Services of the State of New York, and OTIS R. BOWEN, as Secretary of the United States Department of Health and Human Services, Defendants

NEW YORK CITY HEALTH & HOSPS. CORP. v. PERALES

No. 87 Civ. 4896 (MJL)

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

1991 U.S. Dist. LEXIS 3167

March 18, 1991

COUNSEL:

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ROBERT ABRAMS, Attorney General of the State of New York, Attorney for Defendant Perales, New York, New York, BY: DARREN O'CONNOR, Assistant Attorney General.

JUDGES: Mary Johnson Lowe, United States District Judge.

OPINION BY: LOWE

OPINION: OPINION AND ORDER

Before this Court is plaintiffs' motion pursuant to Fed.R.Civ.P. 56 for summary judgment on Counts I through III of their Complaint. Defendant Otis R. Bowen ("Bowen" or the "Secretary"), Secretary of the United States Department of Health and Human Services, cross-moves for summary judgment on these counts. Defendant Cesar A. Perales ("Perales"), Commissioner of Social Services of the State of New York, also cross-moves under Fed.R.Civ.P. 12(b)(6). For the reasons stated below, defendants' motions are granted and plaintiffs' motion is denied.

BACKGROUND

This action challenges an amendment to a New York State Regulation which, according to plaintiffs, would either reduce or eliminate entirely their federal statutory right to receive certain payments for health care services rendered by them to persons who are eligible for benefits under both the Medicare and Medicaid Programs. Because the issues raised here involve interpretation of a

Congressional act whose construction has been characterized as "Byzantine,"[1] we take some pains to set out the relevant portions of the statutory scheme.

The Medicare Program

Congress established the Medicare Program in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395zz. The Medicare program is a purely federal one and provides reimbursement for medical care to the aged and to certain disabled persons under 65 years of age. Part B of the Medicare Program, with which this litigation is concerned, is a voluntary supplementary program for Medicare-eligibles who choose to enroll. It pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A of the program.

The Part B Medicare Program is financed both through premium payments made by the beneficiary and through contributions from the federal government. The beneficiary is also required to pay an annual deductible. Above that deductible amount, Medicare pays 80% of the "reasonable costs" of hospital services, and 80% of the

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[1] To quote in full:

> "The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the initiated.' "

Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981) (quoting Friedman v. Berger, 547 F.2d 724, 727, n.7 (2d Cir. 1976), cert. denied, 430 U.S. 984 (1977)).

"reasonable charges" of physicians' services.[2] The beneficiary remains responsible for the 20% coinsurance amount.

The Medicaid Program

In 1965, Congress also enacted the Medicaid Program as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq. This program was designed to reimburse certain medical costs for needy persons. The Medicaid Program is a cooperative one, funded by both the federal and state governments. States choosing to participate in it, however, must have their medical assistance plan approved by the Secretary of the United States Department of Health and Human Services (the "Secretary").

Payments under the Medicaid Program are generally not based upon "reasonable costs" or "reasonable charges"; indeed, they are generally lower.[3] Moreover, federal regulations mandate that the state plan require the designated state agency[4] to limit participation in the Medicaid program to providers who accept, as payment

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[2] Those costs and charges are calculated pursuant to the Medicare Act and Regulations.

[3] Plaintiffs argue that New York State has established Medicaid reimbursement rates that are in all cases lower than "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services, and which, in almost all cases, are lower than 80% of such "reasonable costs" or "reasonable charges." See Plaintiffs' Memorandum of Law in Support of Summary Judgment at 9.

[4] In the instant case, the designated state agency is the Department of Social Services of the State of New York (the "Department").

in full, the amount paid for the medical services by the Medicaid program. 42 C.F.R. § 447.15.

The Buy-In Agreement and The Instant Controversy

Under the Medicare statute, 42 U.S.C. § 1395v, a state may enter into an agreement with the Secretary by which it enrolls Medicaid recipients who are also eligible for Medicare ("crossovers" or "dual eligibles") in the voluntary Medicare Part B program. Under this agreement, the state, rather than the beneficiary, pays the Medicare premiums.

New York state has entered into such a buy-in agreement. In addition to paying the premiums under this arrangment, New York also paid, up until January 1, 1987, the full cost-sharing amounts on behalf of its crossover beneficiaries – i.e. the Medicare deductibles and the 20% coinsurance amounts.

On March 16, 1988, however, the Secretary approved a proposed amendment to the New York state plan governing payments under New York's buy-in agreement. That amendment, 18 New York Code of Rules and Regulations ("NYCRR") § 360.10,[5] which became retroactively effective on January 1, 1987, provides that the State's Medicaid agency will pay Medicare co-insurance and deductible amounts for crossovers only up to the

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[5] Since the commencement of this litigation, § 360.10 has been repealed and recodified as 18 N.Y.C.R.R. § 360-7.7, effective March 1, 1989. However, for the purpose of consistency with the papers submitted by the parties, the regulation is referred to in this Order by its original number, 360.10.

approved Medicaid rate. The amendment also prohibits providers agreeing to treat crossovers from seeking to recover, from the patients themselves, any of the Medicare co-insurance or deductible amounts.[6] In short, the amendment requires the provider to essentially treat the crossover patient as a Medicaid recipient and to accept, as payment in full for his Medicare services, an amount no greater than the Medicaid-approved rate.[7]

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[6] Section 360.10 reads in part:

. . . (b) Medical assistance [i.e., Medicaid payments] shall include the amount of any deductible or coinsurance liabilities under Medicare Part B for all eligible applicants or recipients to the extent that:

(1) When the Medicare payment to a provider of a Part B benefit is less than the established medical assistance fee or rate for the benefit, the Department shall pay the provider an amount equal to the difference between the Medicare Part B payment and the lower of:

(i) the established medical assistance fee or rate; or

(ii) the Medicare approved amount.

(2) When the Medicare payment to a provider of a Part B benefit equals or exceeds the established medical assistance fee or rate for the benefit, the Department shall pay no Part B coinsurance or deductible amounts to the provider . . .

(d) Providers of care, services, supplies or equipment covered under Medicare Part B and the medical assistance program shall accept assignment of a person's right to receive Medicare Part B payments and shall not seek to recover Medicare Part B deductible or coinsurance amounts from such person if such person is also eligible for medical assistance.

[7] Operation of the challenged amendment is illustrated below:

On July 10, 1987, plaintiffs – all of whom are health care providers[8] – filed the instant action challenging § 360.10. Specifically, plaintiffs contend that § 360.10 : 1)

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1) If the Medicare payment exceeds the Medicaid rate or fee, Medicaid need not pay any additional amount:

Medicaid Fee or Rate = $ 45

Medicare Approved	Medicare Paid	Balance Due
$ 80	(80% of $ 80) or $ 64	$ 0

2) If the Medicare payment is less than the Medicaid rate or fee, Medicaid must pay the difference between the Medicare Paid amount and the lower of the Medicaid fee/rate or the Medicare approved amount:

Medicaid Fee or Rate = $ 70

Medicare Approved	Medicare Paid	Balance Due
$ 60	(80% of $ 60) or $ 48	$ 12 ($ 60-$ 48)

Medicaid Fee or Rate = $ 50

Medicare Approved	Medicare Paid	Balance Due
$ 60	(80% of $ 60) or $ 48	$ 2 ($ 50-$ 48)

[8] Plaintiff New York City Health and Hospitals Corporation ("HHC") is a New York public benefit corporation and is a principal provider of hospital services, including outpatient hospital services, to the low-income population of New York City who are intended beneficiaries of the Medicaid Act. Complaint at para. 6.

Plaintiff Medical Society of the State of New York ("MSSNY") is a domestic non-profit corporation and is the largest voluntary organization of physicians in New York. Many of its members treat crossovers. Id. at para. 7.

Plaintiff Sidney Finkel, M.D., is a medical doctor who practices in Westbury, Long Island. He is a participating physician in the Medicare program and a provider in the Medicaid program. Id. at para. 8.

Plaintiff John A. Bleski, M.D. is a medical doctor who practices in Kingston, New York. He is a participating physician in the Medicare program and treats a number of regular patients who are dually eligible under both the Medicare and Medicaid programs. Id. at para. 9.

deprives providers, such as themselves, of their claimed statutory right to reimbursement of their reasonable costs or charges in violation of the Medicare Act (Count I); 2) violates the Medicare Act's prohibition of cost-shifting (Count II); 3) violates specified portions of the Medicaid Act's crossover provisions (Count III); and 4) deprives plaintiffs of their property interests in violation of the Due Process Clause of the Fourteenth Amendment (Count IV).[9]

Since the parties first submitted their motions and cross-motions, Congress has twice amended the Medicaid Act in areas relevant to this litigation. Those amendments, and their effect on the instant controversy, are the subject of four letters to this Court and are also taken under consideration here. One such amendment has led plaintiffs to assert a fifth cause of action under the new § 1396(2)(10)(E). However, plaintiffs' Complaint has not been formally amended to state this additional cause of action.[10]

DISCUSSION

Standard of Review

When a court is presented with issues of statutory construction, it must address two essential questions:

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[9] Plaintiffs contend that "in light of the clear statutory violations [enumerated in Counts I-III], it is not necessary to reach the constitutional claim and that [such claim is therefore] not presented on this motion." Plaintiffs' Memorandum of Law at 16-17.

[10] Plaintiffs are hereby directed to formally amend their Complaint, if at all, within thirty days of the date of this Order.

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines that Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, . . . the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron U.S.A. v. Natural Res. Def. Council, 467 U.S. 837, 842-843 (1983). In upholding an agency answer, moreover, "the court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." Id. at 843 n.11. Rather, the agency's interpretation is to be given controlling weight unless it is "arbitrary, capricious or manifestly contrary to the statute." Id. at 844. With this standard set forth, we now turn to the specific arguments raised by the plaintiffs.

Counts I and II

With respect to Count I of their Complaint, plaintiffs argue that the amended § 360.10 denies them their statutory right, under the Medicare Act, to charge Medicare beneficiaries the remaining cost-sharing amounts and/or to recover their reasonable costs/charges. This right,

plaintiffs assert, exists even where the Medicare beneficiary also happens to be eligible under Medicaid.

With respect to Count II, plaintiffs contend that § 360.10 violates the Medicare Act's proscription against cost-shifting, as detailed in 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.80(d). Section 413.80(d) of title 42 of the Code of Federal Regulations provides:

> Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries. (emphasis supplied)

Plaintiffs appear to contend that, by preventing providers from recovering the remaining cost-sharing amounts from either the patient or the state, § 360.10 shifts those unpaid costs onto the providers. The unspoken consequence of this scenario is that the providers will either bear the loss or shift the unpaid portions of their costs/charges onto their non-Medicare/Medicaid patients.

We deal with these contentions together because they both rely upon an essential premise: that by purchasing Medicare Part B coverage for its Medicaid recipients, the State has transformed those recipients, for the purpose of

provider reimbursement, into Medicare beneficiaries. This premise is integral to plaintiffs' claims because, quite logically, the rights and proscriptions of the Medicare Act upon which they rely apply only to Medicare beneficiaries and their Medicare providers.

Plaintiffs support this premise only cursorily in their Reply Memorandum to this Court in which they state:

> It is clear that the services provided to crossovers are services provided under the Medicare program. Payment for such services is [therefore] made, and must be made, pursuant to the Medicare-approved reasonable cost and charges.

Plaintiffs' Reply Memorandum of Law at 9-10 (emphasis in original; footnote omitted). This argument, however, is itself based upon an unsupported premise: that the services a patient receives define that patient's status as a beneficiary and that patient's payment obligations.

In support of its own motion for summary judgment, the Secretary argues that there is nothing in the Medicare Act which makes its reimbursement schedule controlling in the case of a crossover patient. Plantiffs' rebuttal to this – that there is also nothing within the Medicare statute which would preclude application of the Act's policies and proscriptions to crossover patients – does not, however, prove plaintiffs' premise. Rather, it merely underscores the absence of any Congressional directive concerning the treatment of crossovers, one way or the other, for payment purposes. In the absence of any clear Congressional intent on the matter, this Court is therefore

relegated to determining whether the Secretary's interpretation of those payment obligations is based upon a permissible construction of the statutes at issue here.

It has been the Secretary's consistent policy, since at least 1971,[11] to treat crossover patients as primarily Medicaid patients. Streimer Affidavit at para. 5. In formulating this policy, the Secretary, as well as the state, has taken the position that, with respect to buy-in agreements, Medicare plays the role of a third party payor. Indeed, that position appears to be consistent with the relevant federal implementing regulations and with prior case law on the matter. See 42 C.F.R. § 433.136; New York State Dept. of Social Services v. Bowen, 661 F.Supp. 1537, 1551-52 (S.D.N.Y. 1987). It is also a position with which the plaintiffs have no apparent disagreement.[12] Having conceded that point, it is difficult to see how plaintiffs can claim an entitlement to cost-sharing payments

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[11] Policy Information Memorandum No. 6, dated March 4, 1971, states:

> . . . the [state] agency is not necessarily obligated to pay the full amount of the deductibles and coinsurance costs according to the rates established under Title XVIII [Medicare Act], but only that amount which will satisfy the requirement for payment in full according to the Title XIX [Medicaid Act] method of payment.

Reply Affidavit of Peter F. Nadel, Exhibit C.

[12] Rather, plaintiffs argue that these general third party liability provisions cannot be read to implicitly amend § 1396(a)(15) which, they contend, imposes upon the state a specific obligation to pay the cost-sharing amounts of crossovers. Plaintiffs' Reply Memorandum at 33-37. We address plaintiffs' arguments with respect to § 1396(a)(15) infra.

directly from the crossovers. After all, the Medicaid Act, 42 U.S.C. § 1396(a)(25)(C), specifically provides that "the person furnishing the service may not seek to collect from the individual . . . payment of an amount for that service . . . If the total amount of the liabilities of third parties [i.e. Medicare] for that service is at least equal to the amount payable for that service under the [state] plan [i.e. Medicaid]." (emphasis supplied). By forbidding recourse to the beneficiaries, the amendment here challenged merely incorporates this statutory prohibition.

The real target of plaintiffs' claims under the Medicare Act, however, is not the beneficiary, but the state and its Medicaid plan. Plaintiffs' Memorandum at 17. But again, the rules governing payment under third party arrangements do not mandate full payment by the state. Rather, 42 C.F.R. § 433.139(b)(1) provides that "when the amount of [third party] liability is determined, the [state] agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment." The implicit corollary of this regulation is that the state may, but need not, pay more. Plaintiffs' arguable interpretation of § 1396(a)(15) aside, moreover, there is nothing in either the Medicare or Medicaid statutes which even remotely suggests that where the state assumes payment of a recipient's Medicare premiums, it also implicitly assumes payment of that beneficiary's cost-sharing amounts.

Plaintiffs' contention that § 360.10 is violative of the Medicare Act's cost-shifting proscription does not stand on firmer ground. Again, plaintiffs make the very sweeping assumption that the policy considerations underlying

the Medicare Act are wholly applicable to buy-in agreements. Even if we were prepared to make such an assumption, however, one would necessarily have to hold the additional presupposition that § 1395x(v)(1)(A)'s cost-shifting proscription, as plaintiffs characterize it, was intended to protect health care providers and physicians. Yet one need not look beyond the legislative history of that provision and the implementing regulations promulgated thereunder to determine that the intended beneficiaries of this so-called cost-shifting proscription are not health care providers and physicians, but other patients not covered by the Medicare insurance program. While providers and physicians might, as a practical matter, shift those costs onto their non-Medicare patients, that is not an assumption this Court will make in the absence of any evidence or argument by plaintiffs that that is in fact what is occuring. Finally, we note that § 1395x(v) speaks only in terms of "reasonable costs" and can therefore only be deemed applicable to "providers," not "physicians."[13] With respect to those providers, moreover, 42 C.F.R. § 413.80(a) provides that "bad debts attributable to the [unpaid] deductibles and coinsurance amounts are reimbursable under the [Medicare] program." According to the Secretary, such bad debt treatment is available to Medicare providers for their treatment of crossovers. Affidavit of Robert A. Streimer at para. 6.[14] Thus, in the

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[13] Physicians are reimbursed on the basis of their "reasonable charge[s]." 42 U.S.C. § 1395l(a)(1).

[14] I.E., although 360.10 prohibits providers from charging either the patient or the state for unpaid deductibles and coinsurance funds, it does not prevent them from attempting to receive that money from the federally funded Medicare program.

face of this regulation, even providers can hardly argue that § 360.10 makes them the victims of cost-shifting.

In upholding the Secretary's interpretation, we do not mean to suggest that plaintiffs' position with respect the buy-in agreements is wholly unsupportable. What plaintiffs fail to come to terms with, however, is that the buy-in agreements reflect a conflation of aspects of two statutes which, in a very fundamental way, are odds with each other. As all parties acknowledge, Medicare is a health insurance program and is intended to be completely self-supporting. On the other hand, Medicaid is a welfare type program intended to provide financial assistance for the medical assistance of needy persons. Under these circumstances, the Secretary's interpretation of the buy-in agreements as third party arrangements represents a permissible construction of the statutes and a reasonable reconciliation of their conflicting nature. It should be noted that, in almost all cases, total reimbursement to providers will be higher than the Medicaid rate of payment and, in some instances, will even be higher than the Medicare rate of payment. See Examples, supra at 6 n.6.

Count III

Plaintiffs argue that they are entitled to summary judgment on Count III of their complaint, because § 360.10 violates Section 1902(a)(15) of the Social Security Act, codified at 42 U.S.C. § 1396a(a)(15), which they argue requires the states to pay cost-sharing amounts in full.[15]

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[15] As dicussed on page 8, supra, since the commencement of this litigation, § 1396a(a)(15) has been repealed, so discussion

Section 1396a(a)(15) [hereinafter a-15] reads in relevant part that a Medicaid plan must:

> In the case of eligible individuals 65 years or older who . . . are covered by either or both of the insurance programs established by subchapter XVIII [Medicare] of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the the plan) to such individual's income or his income and resources.

Defendants argue that the Secretary has, for a long time, taken the position that a-15 does not require Medicaid to pay Medicare cost-sharing in amounts which would result in providers being reimbursed for a total amount greater than the Medicaid level. Plaintiffs argue that this is an arbitrary and capricious reading of the language. They argue that cost-sharing must be paid in full, by the individual according to his/her income or resources, and the balance by the state.

Defendants point out the fact that a-15 does not explicitly require that providers be paid cost-sharing in full. They argue that when a state plan provides for dually eligible individual's to pay a portion of the cost-sharing, that portion must be determined on a basis reasonably

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of the effect of that section applies only to the situation prior to July 1, 1989, the date on which the repeal became effective.

related to the individual's income and resources. Defendants argue that a-15 was intended, therefore, to protect the interests of the beneficiary, and to insure that already needy beneficiaries are not required to spend, in essence, money that they have already been determined (by their eligibility for Medicaid), not to have for medical care. Defendant Perales' Memorandum of Law in Opposition at 32-35. Defendants point out that this interpretation of a-15 has been accepted as reasonable in other courts. See Samuel v. California Department of Health Services, 570 F.Supp. 566 (N.D.Cal. 1983). The plausibility of defendants' interpretation is somewhat dependent upon the plausibility of their argument that crossover patients are treated by them primarily as Medicaid (and therefore needy), as opposed to Medicare patients. As discussed, supra, defendants have demonstrated to this Court's satisfaction that that has, indeed, been the Secretary's policy. Again, these regulations are complicated, ambiguous, and often apparently conflicting. Defendants' interpretation of a-15 is a rational interpretation, and while other interpretations may also be rational, it would not be appropriate for this Court to overturn the defendants' rational policy.

Conclusion

Therefore, for the reasons discussed, supra, plaintiffs' motion for summary judgment on Counts I-III is denied, and defendants' motions under Fed.R.Civ.Pro.12(b)(6) and 56 are granted.

It Is So Ordered.